Medical Centre

General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 15HDC01387)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 27 March 2012, Mr A, aged 78 years at the time, presented to his general practitioner, Dr C, at Medical Centre 1, with a sore knee, a recent slowing of speech, and a "fizzing" feeling in his feet. Dr C requested blood tests. The results showed that Mr A had a "[m]oderate number of reactive lymphocytes", and the results were referred to a haematologist.

2. On 2 April 2012, Mr A presented to Dr C to discuss his blood test results. Dr C told HDC that he informed Mr A of the initial result of the blood tests, and that at this stage they were awaiting further tests.

3. Dr C sent a referral to the outpatients clinic at Public Hospital 1, owing to Mr A's slowing of speech and his feeling of "fizzing" in his feet. The blood test results that showed the high level of lymphocytes and documented that a further report was to follow from a pathologist were attached to the referral letter. Dr C did not mention Mr A's high lymphocyte levels in the referral letter, or that he was awaiting a supplementary report.

4. On 10 April 2012, Mr A had blood taken for the further tests as requested by Dr C. Later that day, a haematologist reported that the further test results were consistent with chronic lymphocytic leukaemia (CLL). Dr C told HDC that he received the blood test results on 19 April 2012. He documented Mr A's diagnosis as "Chronic lymphatic leukaemia". This information was not forwarded to the outpatients clinic at Public Hospital 1, or discussed with Mr A. Dr C told HDC that he deferred informing Mr A of the diagnosis until Mr A had been reviewed in the outpatients clinic at Public Hospital 1.

5. On 19 April 2012, Dr C received notification that his referral sent on 2 April 2012, regarding Mr A's dysarthria and peripheral nerve issues, had been received by the outpatients clinic at Public Hospital 1. Dr C told HDC that he had the expectation that the results of the investigations would be reviewed by the medical team at Public Hospital 1, and he felt that he had appropriately deputised the outpatients clinic at Public Hospital 1 to follow up on Mr A's CLL.

Findings

6. Adverse comment was made in relation to Medical Centre 1's failure to have a written policy in place in 2012 regarding the communication of test results to patients.

7. Dr C, as the clinician who ordered the blood tests, had a responsibility to communicate to Mr A the diagnosis of CLL and its implications. Provision of this information would have enabled Mr A to be a partner in his own treatment. By failing to inform Mr A of his diagnosis of CLL and its implications, Dr C failed to provide Mr A with information that a reasonable consumer would expect to receive. Accordingly, Dr C breached Right 6(1) of the Code.

8. Dr C also had a responsibility to arrange further assessment of Mr A's condition, put in place an ongoing management plan, and take responsibility for ensuring that he carried out appropriate monitoring of Mr A's condition. By failing to take these

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actions, Dr C failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

9. Dr C had a responsibility to communicate to District Health Board 1 (DHB1) the results of the additional tests he had ordered since the original referral that confirmed a diagnosis of CLL. Mr A's diagnosis of CLL was material information that Dr C had a responsibility to communicate to DHB1. By failing to inform DHB1 of Mr A's diagnosis of CLL, Dr C failed to facilitate co-operation between providers to ensure the quality and continuity of services provided to Mr A. Accordingly, Dr C breached Right 4(5) of the Code.

Recommendations

10. The Commissioner recommended that Dr C:

a) Undertake an audit of his clinical records to ensure that all patient test results he has received in the last six months have been communicated to patients and followed up appropriately.

b) Provide a written apology to Mr A for his breach of the Code.

11. The Commissioner recommended that Medical Centre 1:

a) Review its current policy regarding the management and communication of high priority test results to patients in light of the concerns raised in this report.

b) Audit its compliance with its current policy regarding the communication of test results to patients, and provide HDC with the outcome of that audit.

Complaint and investigation

12. The Commissioner received a complaint from Mrs B about the services provided to her father, Mr A, by general practitioner (GP) Dr C at Medical Centre 1. The following issues were identified for investigation:

- *Whether Dr C provided Mr A with an appropriate standard of care between 2012 and 2013.*
- *Whether Medical Centre 1 provided Mr A with an appropriate standard of care between 2012 and 2013.*

13. An investigation was commenced on 1 June 2016. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs B	Complainant
Medical Centre 1	Provider
Dr C	Provider

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14. Information was also reviewed from:

Medical Centre 2	Medical centre
Dr D	Consultant, Hospital 1
Hospital 1/District Health Board 1 (DHB1)	DHB
Hospital 2/District Health Board 2 (DHB2)	DHB

15. In-house expert advice was obtained from general practitioner Dr David Maplesden **(Appendix A)**.

Information gathered during investigation

16. At the time of these events, Mr A was a registered patient of GP Dr C at Medical Centre 1.

Care provided by Dr C and DHB1

17. On 27 March 2012, Mr A, aged 78 years at the time, presented to Dr C with a sore knee, a recent slowing of speech (dysarthria) and a "fizzing" feeling in his feet, which was occurring "all the time". Dr C requested blood tests to check Mr A's B_{12} and folate levels,[1] and documented that, once the blood test results came back, he would then consider a neurological referral for Mr A. Blood tests were carried out at the medical laboratory on the same day.

18. Later that day, a haematologist at the medical laboratory recorded: "Moderate lymphocytosis.[2] Moderate number of reactive lymphocytes.[3] Haematology result(s) referred to a Pathologist. A further report will follow." Mr A's lymphocyte levels were documented as 6.0 x 10E9/L, with the normal range of lymphocytes documented as being between 1.0–4.0 x 10E9/L. The haematologist also reported that Mr A had impaired glucose tolerance,[4] and recorded Mr A's B_{12} level as being in the normal range at 206pmol/L, and his folate level as being in the normal range at 16.7nmol/L. The pathology report was sent to Dr C.

19. On 29 March 2012, Dr C documented Mr A's diagnosis as "Impaired glucose tolerance".

20. On 30 March 2012, Mr A telephoned Medical Centre 1 and stated that he had an appointment with Dr C the following week to discuss blood test results. During this

[1] B_{12} and folate are two vitamins that are required for normal red blood cell (RBC) formation, and repair of tissues and cells. B_{12} is essential for proper nerve function.
[2] An increase in the number of lymphocytes in the blood. In adults, lymphocytosis is present when the lymphocyte count is greater than 4,000 per microliter (4.0×10^9/L).
[3] Reactive lymphocytes are a type of lymphocyte that increases in size owing to exposure to antigens in the body. Lymphocytes are a type of white blood cell produced by the immune system, and their presence is often due to a viral illness.
[4] Impaired glucose tolerance (IGT) is a pre-diabetic state of hyperglycaemia that is associated with insulin resistance.

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discussion, a registered nurse (RN) informed Mr A of his impaired glucose tolerance result.

21. On 2 April 2012, Mr A presented to Dr C to discuss the blood test results. Dr C documented: "These [blood test results] are largely normal IGT [impaired glucose tolerance] persists lymphocytes a bit high and we are awaiting a supplementary report from the pathologists." Dr C told HDC that he informed Mr A of the initial result of the blood tests, and that at this stage they were awaiting further tests.

22. Dr C sent a referral to the outpatients clinic at Public Hospital 1 owing to Mr A's "[d]ysarthria[5] and peripheral nerve issues[6]" (Mr A's feeling of "fizzing" in his feet). The blood test results that showed the high level of lymphocytes and documented that a further report was to follow from a pathologist were attached to the referral letter. Dr C did not mention Mr A's high lymphocyte levels in the referral letter, or that he was awaiting a supplementary report from the medical laboratory.

23. Dr C told HDC that, on 4 April 2012, he received a further report from a pathologist, which stated: "Persisting lymphocytosis. Suggest a fresh sample for cell marker studies as this is likely to represent early CLL [chronic lymphatic leukaemia]."[7] Because of this, Dr C requested that Mr A have further blood tests. Dr C did not forward the report to the neurology department at Public Hospital 1.

24. On 10 April 2012, Mr A had blood taken for the further tests as requested by Dr C. Later that day, a haematologist at the medical laboratory reported: "The immunophenotype[8] is consistent with chronic lymphocytic leukaemia (CLL)." Dr C told HDC that, on 19 April 2012, he received the blood test results. He documented Mr A's diagnosis as: "Chronic lymphatic leukaemia." This information was not forwarded to the outpatients clinic at Public Hospital 1, or discussed with Mr A.

25. Dr C told HDC that he received the medical laboratory report dated 10 April 2012 on 19 April 2012. He stated:

> "The delay between writing the referral and receiving this information contributed to the mistake I made, as the delay meant I did not adequately recollect the content of my referral and that the referral did not identify CLL as an issue of concern."

26. Dr C told HDC that he deferred informing Mr A of the diagnosis until he had been seen in the outpatients clinic. Dr C stated:

[5] Difficult or unclear articulation of speech that is otherwise linguistically normal — a slowing of speech.
[6] Peripheral nerve issues produce symptoms such as weakness, muscle cramps, twitching, pain, numbness, burning, and tingling (often in the feet and hands).
[7] Chronic lymphocytic leukaemia is a type of cancer in which the bone marrow makes too many lymphocytes (a type of white blood cell).
[8] With immunophenotyping, a blood, bone marrow, or other tissue sample can be tested to gather this information — information that is then used to identify a specific type of leukaemia or lymphoma and, where possible, used to predict its likely aggressiveness and/or responsiveness to certain treatment.

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> "I should have placed a Task to myself to ensure this had happened. At the time I felt the diagnosis of CLL needed to be considered in the context of his investigations[9] in [the] medical clinic before we discussed it further."

27. On 19 April 2012, Dr C received notification that his referral sent on 2 April 2012, regarding Mr A's dysarthria and peripheral nerve issues, had been received by the outpatients clinic at Public Hospital 1. Dr C told HDC:

> "I had the expectation that the results of the investigations I had included would be reviewed by the medical team, and that the further investigations referred to in the laboratory result would be available to the clinic as we share the same laboratory service … It was my expectation that these results would be available to and considered by the outpatient team and that the outpatient team would address these issues as part of the review in clinic."

28. On 21 June 2012, Mr A presented to Dr C for a medication review and to obtain repeat prescriptions. Dr C did not discuss Mr A's CLL with him during this appointment.

29. On 19 July 2012, as a result of Dr C's referral, Mr A presented to the outpatients clinic at Public Hospital 1. Consultant physician Dr D told HDC that this consultation was in relation to "a pins and needles sensation" in Mr A's feet that had been "present intermittently for ten years", and a recent deterioration of speech clarity.

30. During this appointment, because of the above symptoms, a screening neurological examination was performed with consideration of peripheral neuropathy.[10] Dr D documented: "Clinical examinations were abnormal with findings suggestive of peripheral neuropathy/polyneuropathy.[11]"

31. Dr D told HDC:

> "One of the blood test results provided by [Dr C] indicated that there were a moderate number [of] reactive lymphocytes, that the results were referred to a pathologist, and a further report was to follow. This information was all between the laboratory and the GP. We were not asked to comment on this result, and were not provided with the follow-up report. There was no diagnosis of leukaemia at the time of his visit to us for foot tingling and we were not given any follow-up."

32. Following the consultation, Dr D wrote to Dr C and stated:

> "As for possible dysphagia[12] I have requested a semi-urgent CT head[13] for review of possible evidence of infarct[14] and also to exclude underlying brain abnormality.

[9] Investigations in relation to Mr A's dysarthria and peripheral nerve issues.
[10] Peripheral neuropathy refers to the conditions that result when nerves that carry messages to and from the brain and spinal cord from and to the rest of the body are damaged or diseased.
[11] A general degeneration of peripheral nerves that spreads towards the centre of the body.
[12] Difficulty or discomfort in swallowing, as a symptom of disease.

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> I have arranged to see him back in clinic after CT head and will review for need of other investigations, such as nerve studies +/–[15] other allied health referrals such as SLT.[16]"

33. Dr C told HDC that on 8 August 2012 he "received the first clinic letter from [the] outpatient clinic indicating the need for further testing and that [Mr A] would be reviewed further by the outpatient team".

34. On 10 August 2012, a CT brain scan was performed, and the results came back with no abnormalities. Dr D told HDC that the results of the scan did not warrant any further evaluation or treatment. In response to the provisional opinion, Dr C told HDC that Dr D's opinion was not communicated to him.

35. On 20 September 2012, Mr A presented to Dr C and discussed the outpatient review. Dr C told HDC that Mr A's impression at this stage was that tests were pending. Dr C said: "I genuinely thought I had made an appropriate referral to the [outpatients clinic] and had therefore 'deputised' them to follow up on the condition."

36. In response to the provisional opinion, Dr C told HDC:

> "[W]e do not have a dedicated haematologist in our DHB and it is my practice to refer to the outpatients clinic, which can then forward such referrals out of the area if they decide not to manage it themselves."

Consultations at Medical Centre 2

37. In 2013 Mr A relocated to another region, and his clinical notes were transferred from Medical Centre 1 to Medical Centre 2. Between March 2013 and March 2015, Mr A consulted with GPs on numerous occasions. Blood tests were requested regularly, and it appears that Mr A's CLL was being monitored.

Appointment at Hospital 2

38. On 8 September 2015, Mr A attended a surgical pre-admission appointment regarding pending knee surgery. During the appointment, the RN went through Mr A's medical history, gleaned from his GP's letter to the clinic. The RN told HDC that when she mentioned Mr A's CLL to him, he informed her that he did not have CLL. The RN told HDC that she queried with Mr A whether he knew that he had abnormalities with his blood. The RN said: "To the best of my knowledge his reply was, 'Well, yes that's true.'"

39. Mr A told HDC:

> "I was interviewed by a nurse on my particulars and health and in the process while looking through my records she stated that I had leukaemia. This came as a

[13] A computerised tomography (CT) scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images of the bones, blood vessels, and soft tissues in the body.
[14] A small localised area of dead tissue resulting from failure of blood supply.
[15] Stimulation of the nerves.
[16] Speech language therapy.

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> total shock to us both. We had never heard of this but she mentioned blood tests done [before I moved] … My understanding [was that] previous blood tests were for Blood Pressure and Cholesterol."

Further information

Dr C

40. Dr C told HDC:

> "On reflection I accept that I should have reviewed my original referral letter as despite including the original abnormal full blood count indicating a lymphocytosis, I obviously did not include a discussion of this and the fact that there were further tests pending in my letter. In the future I will ensure any supplementary reports are communicated directly with the Outpatients clinic.
>
> …
>
> On review of the overall situation my mistake was in not recognising that my initial referral was not sufficiently specific, and did not address this issue directly."

Medical Centre 1

41. The practice manager told HDC:

> "At the time of the incident [Medical Centre 1] had no documented policy on the management and provision of medical results to patients. However, [Medical Centre 1's] undocumented policy has been that the practice would endeavour to contact patients with abnormal results, the receiving doctor tasking the Practice Nurse to contact the patient regarding the course of follow-up. All patients were and still are advised to make contact with the practice when they are expecting results."

42. Medical Centre 1 has since created a documented policy entitled "Managing Results", which outlines when and how patients are to be contacted. The policy also considers how results deemed high priority should be actioned, and requires the nurse to:

> "[m]ake 6 attempts to contact at intervals of 2 working days … using different methods available … After 6 unsuccessful attempts, an alert should be set on the patient file and the **task returned to the GP who initiated the task**." (Emphasis in original.)

43. Medical Centre 1 told HDC: "The requesting doctor (or deputy) receives the test results in the first instance and clinically urgent results will be (and have always been) managed by the doctor when received." Medical Centre 1 stated that it will now revise the "Management of Results" policy so that it also addresses how clinically urgent results are to be dealt with by GPs.

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Response to provisional opinion

44. The parties were given an opportunity to comment on the relevant sections of the provisional report. These responses have been incorporated into the report where appropriate.

45. Mr A and Mrs B had no further comments regarding the "information gathered" section of the provisional opinion.

46. Dr C stated:

> "I have read your Provisional Opinion closely and reflected on the comments made. Overall, I think that the comments made are fair. Although I exercised due skill and care in the investigation and diagnosis of [Mr A's] conditions, I acknowledge that I let [Mr A] down in terms of my referral to, and coordination with, [the outpatients clinic]."

Opinion: Medical Centre 1

Lack of policy on managing test results in 2012 — adverse comment

47. Medical Centre 1 advised HDC that in 2012 it had "no documented policy on the management and provision of medical results to patients". Medical Centre 1 stated:

> "[Medical Centre 1's] un-documented policy has been that the practice would endeavour to contact patients with abnormal results, the receiving doctor tasking the Practice Nurse to contact the patient regarding the course of follow-up."

48. My expert advisor, GP Dr David Maplesden, advised me:

> "With regard to the absence of a formal written policy on handling of test results in 2012, I would be mildly to moderately critical of such a situation given the publicity this issue had received from the HDC in 2001[17] and 2008,[18] with an advisory statement from the RNZCGP in 2005[19] recommending practices *have a clear, documented policy covering: patient notification; the process for tracking and managing tests ordered including identifying missing results (particularly significant results); staff responsibilities (including results interpretation), actions and follow-up — all in a clinically appropriate and timely manner.*"

49. Medical Centre 1 should have had in place a formal written policy that outlined the manner in which test results were to be received and actioned appropriately. A written and established policy that placed the onus on the GP who ordered the tests to ensure

[17] http://www.hdc.org.nz Article: Patient Test Results Again
[18] http://www.hdc.org.nz Article: Managing Patient Test Results
[19] RNZCGP. Managing patient test results. 2005 (revised 2016).

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that those test results were communicated to patients appropriately, could have provided an additional safeguard against such an error occurring.

50. Furthermore, I note that Medical Centre 1 told HDC: "All patients were and still are advised to make contact with the practice when they are expecting results."

51. Previously this Office has stated that it "[does] not believe that it is the patient's responsibility to follow up test results; certainly not when it has been agreed in advance that the patient will be notified of abnormal test results".[20] I maintain this view.

52. I am critical that at the time of these events there was no written policy in place at Medical Centre 1 regarding the communication of test results to patients.

53. I note that Medical Centre 1 has since created a policy entitled "Managing Results", which outlines how test results are to be managed, and when and how patients are to be contacted. The policy also considers how results deemed to be high priority should be actioned, and requires the nurse to:

> "[M]ake 6 attempts to contact at intervals of 2 working days … using different methods available … After 6 unsuccessful attempts, an alert should be set on the patient file and the **task returned to the GP who initiated the task**." (Emphasis in original.)

54. Dr Maplesden advised:

> "I am somewhat concerned that results deemed to be of the highest priority in nature … are not referred back to the GP until six attempts at contact have been made over up to 10 days (two days between attempts). This would be inappropriate management for many high priority results … and I feel the policy would be best amended so that such results are discussed with the GP immediately if several attempts at contact have been unsuccessful on the day the results have been received."

55. I am concerned that the current policy may allow results that have been deemed as high priority to remain uncommunicated to the patient for ten days before the result is referred back to the GP. In response to the provisional opinion, Medical Centre 1 told HDC that it intends to "amend the Management of Results policy so it addresses how clinically urgent results are to be dealt with by GPs".

Opinion: Dr C

56. On 27 March 2012, Mr A presented to Dr C with a sore knee, a recent slowing of speech, and a "fizzing" feeling in his feet that was "occurring all the time". Dr C

[20] Patient Test Results Again (19 March 2002).

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requested blood tests to check Mr A's B_{12} and folate levels. The report from the medical laboratory stated: "Moderate lymphocytosis. Moderate numbers of reactive lymphocytes. Haematology result(s) referred to a Pathologist."

57. On 2 April 2012, Mr A presented to Dr C to discuss the blood test results. Dr C sent a referral to the outpatients clinic at Public Hospital 1, owing to Mr A's "[d]ysarthria and peripheral nerve issues". The blood test results were attached to the referral letter. However, Dr C did not mention, in the body of the letter itself, Mr A's lymphocyte levels or that he was awaiting a supplementary report from a pathologist.

58. On 4 April 2012, Dr C received a further report from the medical laboratory, which stated: "Persisting lymphocytosis. Suggest a fresh sample for cell marker studies as this is likely to represent early CLL."

59. On 10 April 2012, a haematologist at the medical laboratory sent Dr C a report that stated: "The immunophenotype is consistent with chronic lymphocytic leukaemia (CLL)." Dr C did not inform Mr A of this diagnosis, nor did Dr C forward the information to the outpatients clinic at Public Hospital 1.

60. Dr C told HDC:

> "I had the expectation that the results of the investigations I had included would be reviewed by the medical team, and that the further investigations referred in to the laboratory result would be available to the clinic as we share the same laboratory service … It was my expectation that the results would be available to and considered by the outpatient team and that the outpatient team would address these issues as part of the review in clinic."

61. Dr C did not arrange any further assessment of Mr A's condition, or put in place any ongoing management and monitoring.

62. The Medical Council of New Zealand's publication *Good Medical Practice* (2008) requires clinicians to "have systems in place to ensure that test results are acted upon in a timely manner, including notification of patient as appropriate".

63. Dr Maplesden advised that, on receipt of the results indicating a diagnosis of CLL, he would expect the clinician to communicate to the patient, in a timely fashion, the results of that test and the implications of the condition.

64. I am concerned that although Dr C requested the blood tests and received the results, he did not ensure that Mr A was aware of his diagnosis. As this Office has stated previously, doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal test results. The primary responsibility for following up abnormal test results rests with the clinician who ordered the tests.

65. Dr Maplesden advised that he would also expect the requesting clinician to:

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- have the knowledge of, or seek appropriate advice in regard to, or formally deputise responsibility for, the appropriate assessment and ongoing management/monitoring of the patient in relation to the diagnosis of CLL; and

- take responsibility for ongoing management of the patient's condition and put in place processes to ensure that appropriate monitoring (physical and lab testing) is undertaken in a timely manner.

66. Dr C told HDC that he thought that he had deputised the outpatient unit to follow up on Mr A's condition. Dr Maplesden advised that the "deputisation" for ongoing management of Mr A "would be by way of formal referral of the patient by the GP to a haematologist, requesting review and advice regarding further management". Dr C told HDC that, while he agrees that this is ideal, there is no "dedicated haematologist" in their DHB.

67. Dr C did not ask DHB1 to consider Mr A's lymphocyte levels in his letter of referral, or provide DHB1 with a copy of the further reports received on 4 April 2012 and 10 April 2012.

68. Accordingly, I do not consider that Dr C "deputised" DHB1 to follow up on Mr A's test results. Further, at no stage did Dr C receive any indication from the DHB that it was aware of Mr A's diagnosis of CLL, or that the diagnosis and its management had been discussed with Mr A.

69. I agree with Dr Maplesden's advice that the failure by Dr C to notify Mr A of his CLL diagnosis and the implications of the condition, and to put in place a formal management programme, represents a moderate departure from expected standards of care.

70. Dr Maplesden further advised that in this case:

> "… [Dr C] also had a responsibility to ensure the CLL diagnosis and related blood test results were communicated to the [DHB1 outpatients clinic] rather than assuming [DHB1] staff would proactively search the community lab database when there was no obvious reason to do so …".

71. I agree. I do not believe it was reasonable for Dr C to expect that DHB1 would search the community lab database in these circumstances. Dr C had a responsibility to communicate the diagnosis of CLL and the related blood test results directly to DHB1.

72. As the clinician who ordered the blood tests, Dr C had a responsibility to communicate the diagnosis of CLL and its implications to Mr A. Provision of this information would have enabled Mr A to be a partner in his own treatment. By failing to inform Mr A of his diagnosis of CLL and its implications, Dr C failed to provide Mr A with information that a reasonable consumer would expect to receive and, accordingly, breached Right 6(1) of the Code.

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73. Dr C also had a responsibility to arrange further assessment of Mr A's condition, put in place an ongoing management plan, and take responsibility for ensuring that he carried out appropriate monitoring of Mr A's condition. By failing to take these actions, Dr C failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

74. Dr C had a responsibility to communicate to DHB1 the results of the additional tests he had ordered since the original referral that confirmed a diagnosis of CLL. Mr A's diagnosis of CLL was material information that Dr C had a responsibility to communicate to DHB1 in these circumstances, where the results were received by him between his referral to DHB1 and the patient being seen by DHB1. By failing to inform DHB1 of Mr A's diagnosis of CLL, Dr C failed to facilitate co-operation between providers to ensure the quality and continuity of services provided to Mr A, and, accordingly, Dr C breached Right 4(5) of the Code.

Recommendations

75. I recommend that Medical Centre 1:

a) Review its current policy regarding the management and communication of high priority test results to patients, in light of the concerns raised in this report. Medical Centre 1 should report back to this Office with the outcome of the review and changes made as a result, within four weeks of the date of this report.

b) Audit its compliance with its current policy regarding the communication of test results to patients, and provide HDC with the outcome of that audit, within three months of the date of this report.

76. I recommend that Dr C:

a) Undertake an audit of his clinical records to ensure that all abnormal patient test results he has ordered in the last three months have been communicated to patients and followed up appropriately. Dr C should provide evidence to this Office of this audit and its outcome within three months of the date of this report.

b) Provide a written apology to Mr A for his breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

Follow-up actions

77. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name.

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78. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal New Zealand College of General Practitioners, and it will be advised of Dr C's name.

79. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Advice to the Commissioner

The following expert advice was obtained from general practitioner Dr David Maplesden:

> "1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Mrs B], daughter of [Mr A]; response from [DHB1] and relevant [Public Hospital 1] clinical notes; response from [DHB2] and relevant [Public Hospital 2] clinical notes; response from GP [Dr C] and [Medical Centre 1] notes; [Medical Centre 2] notes.
>
> 2. [Mrs B] complains that her father, [Mr A], was evidently diagnosed with chronic lymphocytic leukaemia (CLL) following blood tests in March and April 2012 but was never told of the diagnosis. She attributes blame for this oversight to [DHB1] staff as she thinks the blood tests were ordered by them. She states [Mr A] was informed of the diagnosis when he attended a [Hospital 2] pre-assessment clinic in September 2015. [Mrs B] also complains that *some brain tests Dad had done at [his previous town] are not on file either.*
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> 3. Brief synopsis from notes and responses on file
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> (i) 27 March 2012 — patient seen by [Dr C] with symptoms suggestive of peripheral neuropathy and slowing of speech. Blood tests ordered by [Dr C] and undertaken the same day. Blood count showed moderate lymphocytosis (lymphocytes $6.0x10^9$/L — normal range 1.0–4.0) with pathologist comment *Moderate numbers of reactive lymphocytes. Haematology result(s) referred to a pathologist. A further report will follow.* HbA1c result was suggestive of impaired glucose tolerance (IGT).
>
> (ii) 2 April 2012 — [Dr C] discussed blood results with [Mr A]. Notes include: *these are largely normal IGT persists, lymphocytes a bit high and we are awaiting a supplementary report.* Referral made to [Public Hospital 1] Neurology outpatients in relation to symptoms described above and enclosing a copy of current results.
>
> (iii) 4 April 2012 — [Dr C] received pathologist comment in relation to previous blood count: *Persisting lymphocytosis. Suggest a fresh sample for cell marker studies as this is likely to represent early CLL.* The same day [Mr A] was sent a letter and lab form requesting the appropriate tests. [Public Hospital 1] records indicate the neurology referral was also triaged on this day and an appointment made for [Mr A] for 19 July 2012.
>
> (iv) 19 April 2012 — [Dr C] received additional results showing *cell markers consistent with chronic lymphocytic leukaemia (CLL)* (sample taken 10 April 2012) and entered a disease code *chronic lymphatic leukaemia.* [Dr C] states around this time he also received notification from [Public Hospital 1] that the neurology referral had been received and he assumed all blood results would be reviewed at this appointment and the diagnosis would be discussed with [Mr A].

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He did not discuss the diagnosis with [Mr A] himself. I note none of the additional results received were copied in to [Public Hospital 1] outpatients nor were any copies forwarded by [Dr C]. [Dr C] states that DHB staff have access to community laboratory results. On 22 May 2012 [Dr C] received a blood count result ordered by [a DHB surgeon] (I cannot determine the circumstances leading to this test being requested) with the comment *Clinical details given as chronic lymphocytic leukaemia*) strengthening his belief that DHB staff were aware of the blood results and would discuss the diagnosis and its implications with [Mr A].

(v) 21 June 2012 — patient seen by [Dr C] for repeat of regular medications. No discussion of CLL diagnosis recorded. No physical examination pertinent to diagnosis of CLL recorded (see [DHB2 guidelines] although [Dr C] was evidently not aware of the presence of these guidelines available since 2005).

(vi) 19 July 2012 — [Mr A] seen in [Public Hospital 1] Neurology OP by [a registrar]. Relevant physical history recorded in the clinic letter to GP together with comment *Bloods (27 March 2012) as provided by yourself* [some listed] … *he has normal blood count and U&Es* … Repeat blood tests related to Vitamin B12 metabolism were arranged together with semi-urgent head CT scan. There is no reference to diagnosis of CLL or any discussion in this regard. The letter concludes: *I have arranged to see him back in clinic after CT head and will review need for other investigations such as nerve studies +/- other allied health referrals such as SLT.*

(vi) Additional blood tests taken on 19 July 2012 (vitamin B12, folic acid and methyl malonate) all normal (copies on GP file). Head CT scan undertaken on 10 August 2012 (copy to GP and result in GP notes) also normal. The DHB response notes [Mr A] was sent an appointment for 1 October 2012 but he did not attend on that date. As this was a routine appointment to discuss his normal results no further appointments were sent. The DHB response confirms that no blood tests were ordered by [outpatient clinic] staff in relation to [Mr A's] diagnosis of CLL, nor were staff aware of this diagnosis or the abnormal results suggestive of that diagnosis ordered and received by [Dr C].

(vii) 20 September 2012 — [Mr A] reviewed by [Dr C] for repeat medications. Notes include: *there are no signs of a vit B12 deficiency, the CT scan is all normal, we are awaiting clinic review for more investigations.* On this occasion it appears [Mr A's] lymph nodes were palpated. [Mr A] was not seen subsequently by [Dr C]. A repeat prescription was provided per telephone on 11 December 2012 and a notes transfer request was received from [Medical Centre 2] on 5 March 2013. There was no repeat CBC on file after the result of 22 May 2012 to suggest an intention to monitor [Mr A's] blood count as per guideline recommendations.

(viii) 20 March 2013 — [Mr A] seen at [Medical Centre 2] for repeat of usual medications. CLL diagnosis recorded in patient classifications on that day. Clinical notes are brief: *new patient, well in himself 130/80.* Flu vaccine administered the same day and blood tests ordered and undertaken on 22 March 2013 (lymphocytes 7.9 — haematology comment *Clinical details given as chronic*

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lymphocytic leukaemia). The result has been annotated by [provider initials] as *need notes* but plans for monitoring/follow-up are not evident from the clinical notes. IGT was monitored in May 2013.

(ix) 26 June 2013 [provider initials] — patient seen for repeat meds. No particular issues and physical examination well recorded and unremarkable. 19 July 2013 [provider initials] — consult with otitis externa. 6 September 2013 [provider initials] — consult for knee pain and X-ray ordered.

(x) 23 September 2013 [provider initials] — consult to discuss X-ray results and repeat usual meds. Blood tests ordered: Lymphocytes 11.4 and result annotated [provider initials] as *CML stable.* 18 December 2013 [provider initials] — review of knee arthritis and orthopedic referral made. Usual medications repeated. Bloods ordered — lymphocytes 12.7 (no GP annotation).

(xi) 24 March 2014 [provider initials] — seen for repeat of usual medications and flu vaccine. Bloods ordered with comments: *discussed last blood test and fact that WCC trending up. Discussed repeating again and if increasing will refer haematology. Agrees with this plan. FBC today, if WCC increasing still refer to haematology for further management.* Lymphocytes were 13.5 and [provider initials] referred [Mr A] for urgent haematology review on 26 March 2014. Task was assigned to nurses that day as: *please advise* [Mr A] *did refer haematology today as WCC still increasing (as we discussed) needs to have management plan +/- further investigations.*

(xii) 11 April 2014 — 'advice only' response received from [DHB2] haematology service advising GP follow-up was still appropriate and no specialist intervention was warranted currently. A copy of the DHB CLL guidelines was attached.

(xiii) 16 June 2014 [provider initials] — review for usual medications and tinea. Repeat CBC undertaken (lymphocytes 17). It is not clear from the clinical record whether a formal CLL monitoring or management plan was discussed with [Mr A] at this time. However, at review on 22 September 2014 [provider initials] [Mr A] was well and the comment is recorded *repeat blood test (FBC and HbA1c) due in 3/12 with next script.* It appears the planned monitoring was overlooked at the routine consultation on 18 December 2014 [provider initials] but bloods were repeated following routine consultation on 24 March 2015 [provider initials] with lymphocytes 27.3. Flu vaccine administered 29 April 2015.

(xiv) 5 May 2015 [provider initials] — [Mr A] reviewed with allergic reaction. 18 June 2015 [provider initials] — routine review for repeat prescriptions and URTI. On 26 June 2015 [provider initials] ordered further CBC (lymphocytes 1 July 2015 — 44.3) to be repeated in early September. On 19 July 2015 [provider initials] has recorded *As per CLL guidelines rpt CBC early Sep. If it has doubled since March then needs referral to haem.* Bloods on 8 September 2015 showed lymphocytes 23.9. On 9 September 2015 [Mrs B] rang the practice expressing concern that at the [Hospital 2] pre-assessment clinic the previous day [Mr A] was informed he had CLL diagnosed in 2012 but he had no knowledge of this diagnosis.

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[Information not relevant to the investigation has been removed.]

I feel the management of [Mr A] by [DHB1] was largely consistent with expected standards. The referral letter from [Dr C] contained blood results which appeared unremarkable — an isolated moderate lymphocytosis described as 'reactive' not being an alarming finding but requiring follow-up which was the responsibility of the GP. I do not believe there was any reason for DHB staff to proactively access the community laboratory results at the single consultation on 18 July 2012 and I think it would be reasonably assumed by them that if a significant blood test result had been received by the GP after the referral was sent, the GP would communicate that result to them by telephone or in writing.

5. Comments [Dr C]

On receipt of the laboratory report recommending further blood tests, [Dr C] was conscientious in notifying [Mr A] of the requirement for the tests and supplying him with a lab form, and in coding the diagnosis of CLL once laboratory results were received. On receipt of the results indicating a diagnosis of CLL I would expect the following: the clinician ordering the test communicates the results of that test and its implications with the patient in a timely fashion; the clinician ordering the test has knowledge of, seeks appropriate advice in regard to, or formally deputises responsibility for the appropriate assessment and ongoing management/monitoring of the patient in relation to the diagnosis of CLL; the clinician taking responsibility for ongoing management of the patient's condition puts in place processes to ensure appropriate monitoring (physical and lab testing) is undertaken in a timely manner. In the case in question I believe [Dr C] also had a responsibility to ensure the CLL diagnosis and related blood tests results were communicated to the [DHB1 outpatients clinic] rather than assuming DHB staff would proactively search the community lab database when there was no obvious reason to do so (they were not aware further blood tests had been ordered). I feel [Dr C] was remiss in not discussing the diagnosis of CLL directly with [Mr A] immediately following the diagnosis, particularly when he was not aware when [Mr A] would be reviewed in the outpatient clinic (or if he was aware, the appointment was over three months away) and particularly when the outpatient clinic report, once received, made no reference at all to a diagnosis of CLL. [Mr A] required a focused symptom and physical assessment following the diagnosis in order to confirm the stage of his condition which would in turn affect his management and monitoring plan. I could not see that such an assessment was undertaken (although lymph nodes were apparently palpated at a consultation some five months after the diagnosis), and the blood count was not repeated between May 2012 and the time a request for transfer of notes was received in March 2013. Overall, I feel [Dr C's] management of [Mr A] in relation to communicating to him the diagnosis of CLL and its implications, and in relevant assessment and monitoring (whether or not this required seeking specialist advice if [Dr C] was not aware of the local guidelines), departed from expected standards to a moderate degree. I acknowledge there was no physical harm done to [Mr A] through these oversights as the nature and extent of his condition did not actually require any active treatment while he was under [Dr C's] care although this comment is made with the benefit of hindsight."

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The following further expert advice was obtained from Dr Maplesden:

> "Thank you for requesting review of further documentation received regarding this file. The following advice should be reads in conjunction with my original advice.
>
> 1. Response from [Medical Centre 1] dated 27 June 2016
>
> The response notes that [Medical Centre 1] did not have a formal written policy in place for management of tests results at the time of the events in question, but an undocumented policy was in place which was *that the practice would endeavour to contact patients with abnormal results, the receiving doctor tasking the Practice Nurse to contact the patient regarding the course of follow-up.* The practice has since implemented a written policy. The current policy has been reviewed and appears similar in many respects to results policies I have reviewed from other practices, but has specific 'priority' codes attached which determine the nature and timing of communication regarding a result. I am somewhat concerned that results deemed to be of the highest priority in nature (category H) are not referred back to the GP until six attempts at contact have been made over up to 10 days (two days between attempts). This would be inappropriate management for many high priority results (eg markedly elevated INR) and I feel the policy would be best amended so that such results are discussed with the GP immediately if several attempts at contact have been unsuccessful on the day the results have been received. With regard to the absence of a formal written policy on handling of test results in 2012, I would be mildly to moderately critical of such a situation given the publicity this issue had received from the HDC in 2001[1] and 2008[2], with an advisory statement from the RNZCGP in 2005[3] recommending practices *have a clear, documented policy covering: patient notification; the process for tracking and managing tests ordered including identifying missing results (particularly significant results); staff responsibilities (including results interpretation), actions and follow-up — all in a clinically appropriate and timely manner*. This advice has been reiterated in an April 2016 update of the original document.
>
> 2. Response from [Dr C] dated 21 June 2016
>
> [Dr C] states he was not aware of the [DHB2] guidelines on management of CLL referred to in my original advice, and his own DHB does not have such guidelines available. [Mr A's] appointments at [Public Hospital 1] in 2012 were with the general medical rather than neurology service, and [Dr C] was not notified when [Mr A] failed to attend the follow-up appointment scheduled for 1 October 2012. [Dr C] reiterates that he was under the impression the DHB general medical service would discuss with [Mr A] the diagnosis of CLL and the management required for the condition. I remain of the view that the failure by [Dr C] to notify

[1] http://www.hdc.org.nz Article: Patient Test Results Again
[2] http://www.hdc.org.nz Article: Managing Patient Test Results
[3] RNZCGP. Managing patient test results. 2005 (revised 2016). Both versions are normally available on the RNZCGP website but a recent update of the website (July 2016) appears to have led to broken links.

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> [Mr A] of his CLL diagnosis and the implications of the condition, and to put some formal management programme in place, represents a moderate departure from expected standards of care. At no stage between receiving confirmation from the laboratory that [Mr A] had a diagnosis of CLL (19 April 2012) and [Mr A's] transfer from the practice in December 2012 did [Dr C] receive any indication from [the DHB's] general medical service that they were aware of [Mr A's] diagnosis of CLL or that the diagnosis and its management had been discussed with [Mr A]. It does not appear that [Dr C] sought any specialist information regarding management of CLL (recommended assessments, monitoring of bloods and threshold for specialist review). This has been discussed more fully in my original advice and there is no new information provided in the most recent response that alters my original advice in this regard. However, [Dr C] lists several remedial actions taken since [Mr A's] complaint and these are appropriate. I note that on 11 December 2012 a classification of CLL was entered into [Mr A's] notes by [provider initials], just prior to [Mr A's] transfer to [Medical Centre 2]. I interpreted the consultation on this date as a telephoned request for repeat prescriptions but I am unsure of the identity of [provider initials] or the circumstances leading to the formal documentation of this classification some eight months after the diagnosis."

The following further expert advice was obtained from Dr Maplesden on 18 April 2017:

> "In the case mentioned, the deputisation for ongoing management of this patient would be by way of formal referral of the patient by the GP to a haematologist, requesting review and advice regarding further management. In other cases, the person ordering the test might request in writing that another provider follows up the results eg in ED discharge summaries it is increasingly common practice for the ED clinician to request the GP to follow-up blood results. Such a request needs to be explicit and clearly documented, ideally with some mechanism that enables notification of the requester that the request has been accepted by the 'deputy'."

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