Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 20HDC00248)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report relates to the care provided to a woman by a doctor at a medical centre. Following a hospital admission, the discharge summary recommended that the woman be referred for an abdominal ultrasound and to cardiology outpatient services. However, the doctor did not action the referrals in a timely manner, and subsequently the woman was diagnosed with neuroendocrine cancer.

2. The report highlights the importance of critical thinking and of actioning referrals in a timely manner, and of doctors implementing strategies to mitigate the risks associated with a high workload.

Findings

3. The Commissioner found the doctor in breach of Right 4(1) of the Code for the unacceptable delay in management of the woman's referrals. The Commissioner considered that despite the doctor's high workload and staffing issues at the time, he ought to have implemented strategies to mitigate the associated risks.

4. The medical centre was not found in breach of the Code.

Recommendations

5. It is recommended that the doctor report back to HDC regarding the additional strategies he has implemented to ensure that referrals are acted on as soon as possible, and the strategies that will assist him during particularly busy periods and staff shortages.

6. It is recommended that the medical centre review the current strategies used to ensure that staff action the advice from other providers; provide evidence that all current staff have received training on the new "Management of Clinical Correspondence, Test Results and Other Investigations Policy and Process"; and undertake an audit of 10 randomly selected patient referrals to ensure that the new practice policy regarding tracking and follow-up of referrals is being followed.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by Dr B at the medical centre. The following issues were identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care in 2019.*
- *Whether the medical centre provided Ms A with an appropriate standard of care in 2019.*

8. The following parties were directly involved in the investigation:

Ms A	Consumer/complainant
Dr B[1]	Doctor at the medical centre
Medical centre	Clinic/group provider

9. Further information was received from:

Dr C[2]	Doctor at the medical centre
District health board/public hospital	

10. Independent in-house clinical advice was obtained from general practitioner (GP) Dr David Maplesden (Appendix A).

Information gathered during investigation

Background

11. Ms A (aged in her sixties at the time of events) was a patient at the medical centre. She had multiple health issues, which included a history of epigastric pain,[3] diarrhoea, depression, and episodes of intermittent heart palpitations since November 2018.[4]

10 January 2019 — presentation to public hospital

12. On 10 January 2019, Ms A presented to the Emergency Department (ED) at a public hospital with stomach pain and other symptoms.[5] The ED doctor found Ms A to be "systemically well", and that her pain could be managed with simple pain relief. She was discharged from the hospital on the same day.

13. The discharge letter to Ms A's doctor documented that the suspected cause for the abdominal pain was gallstones, and Ms A was advised to see her family doctor the following day. The letter stated: "Please see your [doctor] tomorrow and he/she will organise an outpatient ultra-sound scan of your tummy to check for gall stones."

14. The advice to the doctor included:

a) To organise an outpatient stomach ultrasound[6] to check for gallstones.

[1] Dr B is not vocationally registered.
[2] Dr C is not vocationally registered.
[3] Epigastric pain generally affects the area immediately below the ribs.
[4] Ms A also had a hip problem and had suffered from a chest infection in December 2018.
[5] Diarrhoea, hot flushes, increased urinary frequency, and heart palpitations.
[6] Abdominal ultrasound.

b) To refer to outpatient cardiology for a heart monitor[7] to check for abnormal rhythms during palpitations.[8]

11 January 2019

15. On 11 January 2019, Ms A saw Dr B[9] at the medical centre. Dr B told HDC that before the consultation with Ms A, he reviewed the ED discharge letter from the hospital.

16. Dr B's consultation notes record that Ms A was "coming for review of [abdominal] pain, seen at [the] ED last night". Ms A also complained of intermittent palpitations but was noted to be "well now, with no chest pain". Dr B documented that Ms A was "feeling better today".

17. On examination, Dr B noted that Ms A was not feverish but had some tenderness around the abdominal area, and his impression was of non-specific abdominal pain and intermittent palpitations. His documented plan was to prescribe medication to relieve Ms A's stomach pain,[10] refer her for an abdominal ultrasound and outpatient cardiology services, and for Ms A to consume a soft diet[11] for the next few days.

18. Despite Dr B's documented intention, the referrals for an ultrasound and outpatient cardiology services were not actioned.

19. Dr B acknowledged to HDC that he overlooked both referrals. He said that his usual practice was to complete the referrals on the electronic referral system[12] while the patient was still in the consultation room, but often the medical centre's electronic referral system was slow or off-line for a period of time, and this may have been so on the day of the consultation, thereby contributing to the error. His back-up process was to maintain a written list but, nevertheless, the referrals were overlooked on the day. Dr B said that his oversight was a result of human error, as he was "exceptionally busy" in early 2019.

20 March 2019

20. On 20 March (approximately two months after her last consultation), it was recorded in the consultation notes that Ms A presented to Dr B for her ACC certificate renewal[13] relating to torn left calf muscles. The notes document that Ms A was still experiencing intermittent stomach pain. On examination, Dr B observed that Ms A's abdomen was generally soft but that there was tenderness around the right upper quadrant. His documented impression was "likely gallstones/biliary colic[14]". He recorded his plan as "referred for USS[15]".

[7] A Holter monitor — a type of portable electrocardiogram (ECG) to monitor electrical activity of the heart.
[8] Supraventricular tachycardia (a rapid heartbeat that develops when the normal electrical impulses of the heart are disrupted) was suspected.
[9] Dr B has many years of experience as a doctor. He joined the medical centre in 2015.
[10] Buscopan Forte — a medicine used to relieve stomach pain and bowel cramps by helping the digestive system to relax.
[11] Food that is soft and easy to chew and swallow.
[12] MedTech electronic referral system.
[13] Ms A received ACC compensation for a left calf injury suffered in 2016.
[14] Pain caused by gallstones passing or a blocked bile duct.
[15] Ultrasound.

21. Dr B told HDC that at this consultation he was informed by Ms A that she had not received an appointment for an ultrasound. Ms A was then told by Dr B that her ultrasound referral would be actioned.

22. At 10.15am, Dr B completed a referral to the DHB for an abdominal ultrasound. On the same day, the ultrasound referral was declined. The DHB explained that this was because of resource constraints, and advised Dr B to request a community ultrasound.

23. Despite the clear recommendation made by the DHB, the community ultrasound for Ms A was overlooked by Dr B and was not actioned. Ms A told HDC that she cannot understand why Dr B did not arrange for the community ultrasound immediately, given the clear recommendation in the January 2019 discharge letter.

24. Dr B explained to HDC that his usual practice when receiving clinical correspondence is as set out in the medical centre's "Patient Test Results, Correspondence and Reports" policy (see Appendix B), but on this occasion, he filed the DHB letter without completing the recommended community radiology referral or setting up a task on the MedTech electronic referral system. Dr B said that this was human error.

25. Dr B told HDC that the cardiology assessment for Ms A's palpitations was not followed up because the focus of the presentation was the extension to Ms A's ACC certification. Dr B said that during Ms A's presentation he was reassured that there were no indications of any serious underlying health issues that required urgent assessment.

26. However, Ms A told HDC: "[N]othing was done about [the] Holter monitor and my palpitations either." She said that her palpitations were significant and continued to be part of her ongoing health condition.

April–November 2019

27. Ms A presented to the medical centre between April and November 2019 for multiple consultations about a number of medical conditions, and primarily saw Dr C. The abdominal ultrasound referral was not documented again until an appointment with Dr C on 16 October 2019. A summary of the relevant presentations is set out below.

Cardiology referral action taken

28. On 14 May, Ms A presented to the medical centre with ongoing diarrhoea, and saw Dr C. Management of the diarrhoea is discussed below at paragraph 30. During the consultation, Ms A informed Dr C about her palpitations. Although no discussion about the hospital's discharge letter recommendation for cardiology referral is documented, Dr C lodged a referral to Primary Options for Acute Care[16] on the same day, for investigation of Ms A's palpitations.

[16] A service that provides healthcare professionals access to investigations, care, or treatment for patients, where the patient can be managed safely in the community.

29. On 18 July 2019, the outcome of the assessment was lodged by one of the medical centre's nurses, but there is no further documentation or indication of a discussion with Dr C about Ms A's palpitations.

Colonoscopy

30. In relation to Ms A's presenting complaint, the consultation notes document that Ms A had no rectal bleeding, no weight loss, and no upper stomach symptoms or indication of colon cancer.[17] Dr C told HDC that she specifically asked Ms A about her upper stomach symptoms, and Ms A recalled that she had none, and had no weight loss associated with the diarrhoea. Because of the duration of the diarrhoea,[18] Dr C arranged further investigation by referring Ms A to the gastroenterology service on the same day.

31. Ms A was booked for a colonoscopy[19] at the DHB in six weeks' time.[20] Stool tests were also arranged to exclude other possible causes of the diarrhoea. The colonoscopy was performed on 15 July, and found no significant issues.[21] The report was discussed with Ms A during her consultation with Dr C on 29 July, including the recommendation for a three-year recall. The notes record "nil other concerns".

32. Prior to the referral for the colonoscopy, no digital rectal examination (DRE)[22] was offered to Ms A. Dr C told HDC that she understood that there was no rectal bleeding and no other symptoms to suggest anal/rectal causes for Ms A's longstanding diarrhoea. In response to the provisional decision, Dr C submitted that she made a clinical judgement that Ms A did not have a rectal lesion given Ms A's history and clinical findings.

33. Dr C stated:

> "I did not feel it was clinically indicated at the time, when [Ms A] had significant musculoskeletal pains in relation to her ACCs (multiple) for which she was under ongoing specialist management and no history of rectal bleeding or pain. Doing an unpleasant examination on someone in both physical pain and emotional distress … was not indicated in my opinion."

16 October 2019 — ultrasound referral arranged

34. Ms A presented again to Dr C on 16 October 2019. Ms A told Dr C that she had continued to experience intermittent stomach pains since February, mostly after eating, and that she had

[17] A negative faecal immunochemical test (FIT) was reported for Ms A in the previous year. A FIT screens for colon cancer by testing for hidden blood in the stool.
[18] The consultation notes state this to have been a "few months".
[19] A referral for an endoscopy for suspected colorectal cancer was sent to the DHB's outpatient gastroenterology service. A colonoscopy is a type of endoscopy. The term "endoscopy" is used to refer to examination of the upper digestive tract, whereas "colonoscopy" refers to examination of the large intestine and rectum.
[20] The P2 category colonoscopy meant that Ms A should be examined within six weeks' time.
[21] Non-bleeding haemorrhoids were found (mild) and polyps removed. Histology of the polyps found no dysplasia (abnormal cells) or malignancy (cancer).
[22] A DRE examines a person's lower rectum and other internal organs using a gloved, lubricated finger to feel for abnormal areas.

not yet received the ultrasound scan. Dr C arranged for a community ultrasound referral on the same day.

35. An abdominal ultrasound was performed on 18 October, and found multiple solid masses[23] in the liver, suggestive of cancer, and stones in the right kidney. The ultrasound report was discussed with Ms A on 21 October.

Subsequent events

36. On 22 October, Ms A was admitted to the public hospital. During her stay, various tests were performed to identify the cause of the liver lesions. On 24 October, CT scans found multiple liver lesions. During this admission, Ms A was diagnosed with a rare form of cancer.[24] She was prescribed with medication[25] to treat the cancer, and was discharged on 31 October.

Further information

37. The medical centre advised HDC that carcinoid syndrome and neuroendocrine cancers are very rare and usually very difficult to diagnose. It is unclear whether an earlier ultrasound would have picked up the lesions in the liver. However, the medical centre has acknowledged the importance of acting on all correspondence received by a referrer, and that this was not done by Dr B.

38. The medical centre highlighted that 67% of its patients identify as Māori and Pasifika, and that 80% of its patients are high needs[26] compared to other ethnicities.

39. Dr B told HDC that he acknowledges his involvement in the diagnostic referral delays, and is extremely regretful. He has written a letter expressing his sincere apologies to Ms A for his omissions.

40. An internal review (see Appendix C) was undertaken. The review found that the following factors contributed to the errors by Dr B:

- In early 2019, the medical centre was undergoing a restructure.
- There were staff shortages, including one doctor on leave and two of the doctors working only part time.
- Dr B had a heavy workload and was extremely busy.
- There was an increasing number of patients, with full waiting rooms throughout the day.
- The medical centre did not have a clinical lead in January 2019.

[23] Hypoechoic masses in the liver, with the largest one in the right lobe measuring 55mm.
[24] The primary diagnosis was carcinoid tumour, also known as neuroendocrine tumour. These are tumours that may grow slowly or aggressively, and usually are detected incidentally. The presence of a tumour can cause "carcinoid syndrome", which develops when carcinoid tumours spread to the liver. The carcinoid tumour secretes certain chemicals into the bloodstream, causing a variety of symptoms, including flushing, diarrhoea, heart failure, vomiting, and bronchoconstriction.
[25] Octreotide injection, which is used to control diarrhoea and flushing caused by carcinoid tumours.
[26] The medical centre services a population group with high deprivation and socioeconomic needs.

Responses to provisional opinion

Ms A

41. Ms A was given an opportunity to comment on the "information gathered" section of the provisional opinion. Where relevant, her response has been incorporated above. In Ms A's view, the delay in the ultrasound scan has denied her the chance of an operation to remove the masses in her liver. At the time of writing, her neuroendocrine cancer was at stage 4.

Medical centre

42. The medical centre was given an opportunity to comment on the provisional opinion. The medical centre confirmed that it is happy with the recommendations proposed by HDC and has no further comments to make.

Dr B

43. Dr B was given the opportunity to comment on the provisional opinion. He accepted the findings and the proposed recommendations and follow-up actions, and confirmed that he had no further comments to make.

Dr C

44. Dr C was given an opportunity to comment on the provisional opinion. Where relevant, her response has been incorporated above. She highlighted to HDC that she was managing a series of complex issues for Ms A and provided comprehensive care, given that an ultrasound was arranged immediately she was made aware of the previously missed referrals.

45. Dr C noted that whilst a rectal examination is a recommended part of the pre-referral assessment as per the HealthPathway, this is to ensure that sufficient information is provided for the colonoscopy to be arranged. Dr C was confident that Ms A's significant history was sufficient information for the colonoscopy to be arranged, and this was confirmed by the six-week time frame given.

Opinion: Dr B — breach

46. This report highlights the importance of providers making referrals in a timely manner.

47. It is not disputed that Dr B did not action recommendations to refer Ms A for an abdominal ultrasound and to cardiology outpatient services following her discharge from hospital. The first omission occurred on 11 January 2019, and the second on 20 March 2019. Eventually, 10 months later, Ms A was referred for an ultrasound, which led to a diagnosis of a rare cancer. Although Ms A received a cardiology referral in May 2019, no discussion was documented regarding the discharge letter recommendation.

48. Dr B told HDC that because of staffing issues, the practice was exceptionally busy in early 2019, and this was a significant contributing factor to his errors. He also noted that the medical centre services a large proportion of high-needs patients.

49. My in-house clinical advisor, GP Dr David Maplesden, noted that there were "clear and explicit recommendations contained in the [January 2019] ED discharge summary". He advised that on 11 January, accepted practice would have been for the recommended referrals — for which there were sound clinical indications — to have been completed in a timely manner, and Dr B failed to do this. Dr Maplesden considered that this represented a moderate departure from accepted practice.

50. Dr Maplesden noted that there is individual variation in practice as to how a doctor is reminded to complete a referral. He advised that Dr B "did not apparently have an adequate process in place for recording tasks that required completion outside of the consultation and this led to the referral being overlooked".

51. Dr Maplesden advised that given the initial delays in the referrals being made, on 21 March 2019 he would have expected Dr B to have been particularly conscientious in ensuring that the ultrasound referral was confirmed. Dr Maplesden concluded that the failure by Dr B to complete a community referral for Ms A's ultrasound on this occasion was "at least a moderate departure" from accepted practice, noting that Ms A continued to be symptomatic.

52. In light of the clinical picture and the local guidance for investigation and management of palpitations, Dr Maplesden considered Dr B's overall omission to refer Ms A to cardiology services in January 2019 to be a mild departure from accepted practice.

53. I accept the above advice. I acknowledge that there were staffing issues and the medical centre was busy at the time of events, and I am sympathetic to this. However, with patient safety as a priority, I consider that Dr B needed to ensure that he implemented strategies to mitigate the risks associated with a high workload. The repeated nature of Dr B's omissions to act on the advice and recommendations received from his colleagues suggests that strategies were either ineffective or absent, which is a cause for concern. By 20 March, Dr B had been alerted to his previous error and the resultant delay, but he remained inattentive in his management of Ms A's referrals, which led to a further error. In these circumstances, I consider that Dr B did not provide services to Ms A with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[27]

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

Opinion: Medical centre — no breach

54. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code.

55. It was acknowledged by Dr B that his failure to action Ms A's ultrasound and cardiology referrals was a result of human error.

56. I note in the submissions made by both Dr B and the medical centre that at the time of events the practice was undergoing a restructure and was experiencing staff shortages, which contributed to a high workload for Dr B. Although this may have affected the care Dr B was able to provide to his patients, especially to Ms A, ultimately it remained Dr B's responsibility to provide the appropriate care.

57. My in-house clinical advisor, GP Dr David Maplesden, advised that Dr B's oversight was the result of human error, rather than a practice systems issue. Upon review of the medical centre's policy for management of clinical correspondence and referrals in place at the time of events, Dr Maplesden advised that the policy was fit for purpose and consistent with similar policies he had reviewed from other medical centres. He also advised that the tracking of referrals is at the discretion of the referrer, with individual variation in practice as to how the referrer is reminded to complete tasks.

58. I agree. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the clinic. Therefore, I consider that the medical centre did not breach the Code directly.

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

60. Dr B was an employee of the medical centre. Accordingly, the medical centre is an employing authority for the purposes of the Act. As set out above, I have found that Dr B breached Right 4(1) of the Code for failing to arrange timely ultrasound scans and cardiology assessments for Ms A.

61. I note that Dr B was aware of the medical centre's policy that all incoming referrals for investigations were the responsibility of the doctors, and actioning referrals is well within the knowledge and competence of a doctor of his experience. I consider that actioning referrals and following up results with patients are basic requirements of a doctor working in general practice, and the medical centre should have been able to rely on Dr B's experience in this regard.

62. I am satisfied that the medical centre had taken such steps as were reasonably practicable to prevent the omissions occurring. Accordingly, I do not find the medical centre vicariously liable for Dr B's breach of the Code.

Opinion: Dr C — other comment

63. Dr C saw Ms A at multiple presentations for various health issues during 2019. At the time, she was managing a series of complex issues for Ms A. During these presentations, Dr C understood that Ms A's main symptom was diarrhoea, and that she had no rectal bleeding or upper stomach pain. Dr C arranged for a colonoscopy on 20 May.

64. Dr Maplesden advised that the care provided by Dr C for the investigation of diarrhoea was satisfactory. As this was the predominant symptom, Dr Maplesden was not critical of Dr C's decision to refer for a colonoscopy rather than the recommended ultrasound. However, Dr Maplesden was mildly critical that there was no record of a rectal examination being offered to Ms A or performed prior to the colonoscopy, as recommended in the HealthPathways.[28]

65. Dr C told HDC that she did not offer Ms A a rectal examination as she was satisfied that Ms A's diarrhoea was not associated with rectal pain or bleeding, there was no rectal lesion, and the examination would have caused unnecessary distress to Ms A. Dr C also considered that sufficient information was provided for the colonoscopy to be arranged, and this was confirmed by the six-week time frame given.

66. However, Dr Maplesden advised:

> "My reasoning is that if a rectal mass is detected, the patient qualifies for urgent colonoscopy (within two weeks) as opposed to the 'six week' category based on her existing symptoms (colonoscopy was eventually performed eight weeks following referral) … I therefore remain mildly critical of this omission."

67. I acknowledge that Dr C would have seen Ms A for various health issues and had to prioritise her other health needs at that time. As Dr Maplesden has advised, the general management of Ms A's health was consistent with accepted practice. However, given Dr Maplesden's advice and the recommendation in the HealthPathways regarding offering rectal examination in these circumstances, I encourage Dr C to reflect on this advice and guidance for the future management of patients with similar presentations.

Changes made since complaint

68. Following the events, the medical centre conducted an internal review. As a result of this, Dr B agreed to implement a system to ensure that all referrals are acted on as soon as possible, to avoid overlooking further referrals in the future.

69. The medical centre told HDC that as a result of Ms A's complaint, it has implemented the following changes:

[28] HealthPathways "Colorectal Symptoms".

- It has appointed a full-time clinical lead who is responsible for covering the inboxes for all doctors on leave.
- Doctors have been allocated one hour per day to complete paperwork.
- Doctors are to ensure that referrals are completed during the patient's consultation. There is peer agreement that any tasks to be undertaken will be recorded in writing and checked off at the end of the working day.
- The number of patients seen by the doctors has been reduced to 24–26 per day.
- Staff are encouraged to take leave/breaks/holidays to prevent burnout and promote management of health and wellness.
- Peer review of the case has occurred with existing staff.
- Notes can be accessed securely from home, which has helped to ensure that all referrals are completed in a timely way by the end of the day.

Recommendations

70. I recommend that the medical centre:

a) Review the current strategies staff at the medical centre utilise to action the advice from other providers. The medical centre is to report back to this Office on the review, with any learnings and changes to practice made as a result, within six months of the date of this report.

b) Provide evidence that all current staff are aware of, or have received training on, the new "Management of Clinical Correspondence, Test Results and Other Investigations Policy and Process". The medical centre is to provide evidence of the training within six months of the date of this report.

c) Undertake an audit of 10 randomly selected patient referrals once a month for three months, to ensure that the new practice policy regarding tracking and follow-up of referrals is being adhered to. The results of the audit, and any further remedial actions carried out, should be provided to HDC within six months of the date of this report.

71. I recommend that Dr B report back to HDC regarding the additional strategies he has implemented to ensure that all referrals are acted on as soon as possible, and any additional strategies to assist him during particularly busy periods and when there are staff shortages. This information is to be provided to HDC within three months of the date of this report, including the details of any changes and learnings for his practice.

72. I acknowledge that Dr B provided an apology letter to Ms A, and this has been forwarded to her. I am further satisfied that as a result of this complaint and investigation, Dr B has reflected on the significance of his errors appropriately.

Follow-up actions

73. 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 B's name.

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

Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from GP Dr David Maplesden:

"1. 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 clinical staff 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. I have reviewed the information on file: complaint from [Ms A]; response from [the medical centre]; GP notes from [the medical centre]; clinical notes [DHB].

2. [Ms A] complains about delays in the diagnosis of her cancer which she attributes to a failure by her GPs to organise timely abdominal ultrasound scan. [Ms A] had an abdominal ultrasound performed on 18 October 2019 which showed multiple liver lesions consistent with metastases. Following further investigation, she was diagnosed with a well differentiated neuroendocrine tumour likely originating in the small bowel with metastases to the liver. She is currently receiving medical treatment for the malignancy. A recommendation for referral for abdominal ultrasound was made initially in [an] ED discharge summary dated 10 January 2019. [Ms A] is concerned that despite seeing a GP, [Dr B], following the ED attendance a referral for ultrasound was not made although she was told the referral would be made. A referral was made by [Dr B] following a consultation in March 2019 but this was declined by [the DHB] with a recommendation that referral is made to a community radiology provider. [Dr B] filed this letter without organising the scan. [Ms A] saw her regular GP, [Dr C], in May 2019 complaining of ongoing GI symptoms and was referred for colonoscopy rather than ultrasound. Colonoscopy was performed on 15 July 2019 and showed no signs of colon malignancy. [Dr C] eventually referred [Ms A] for an abdominal ultrasound (community provider) on 16 October 2019 and the scan performed two days later showed the lesions likely to be hepatic metastatic disease.

3. [Ms A's] clinical notes include a past medical history of fibromyalgia, hypertension, previous TIA, obesity, previous DVT and hysterectomy, and depression. She had ongoing musculoskeletal issues with her left leg at the time of the events in question and was under review by orthopedic surgeons with investigations including back, hip and pelvis X-rays, SPECT-CT bone scan, MRI of the hip and lumbar spine and DEXA bone scan undertaken over the period in question. GP notes have been reviewed from October 2018. There were consultations for recent onset dry cough on 6 December 2018 (treated with Amoxil) with cough persisting but clear lung fields noted at review on 17 December 2018. Weight was measured at 77 kg on 6 December 2018. There is no reference to gastrointestinal (GI) symptoms until a consultation of 11 January 2019 following [Ms A's] [ED] attendance.

4. ED discharge summary dated 10 January 2019 includes history: *[Woman in her sixties] presenting with 2/7 history of epigastric pain, tight and colicky in nature, radiating into the back and noticeably worse with food intake and early in the morning on empty*

stomach. Diarrhoea for last 2/7, no blood. No nausea/vomiting. Has been having hot flushes, not sure about fever … Also reports having palpitations since end of November last year. Having at least one episode once per day with associated SOB and feels it is an irregular rhythm. Can feel her heart pounding into her ribs. Physical examination was unremarkable and blood tests showed normal results (including normal liver function). ECG showed sinus rhythm 68 bpm with ventricular ectopics. [Ms A's] symptoms settled with simple analgesia and antacids and she was discharged with paracetamol and Mylanta. There are three separate references to the GP request to organise further investigations:

- In the 'Advice to patient' section: *Please see your GP tomorrow and he/she will organise an outpatient ultra-sound scan of your tummy to check for gall stones. We have also asked your GP to organise an outpatient heart monitor to check for abnormal rhythms for the palpitations that you have described.*
- In the 'Advice to GP' section: *Please arrange outpatient Abdo USS … Please organise an OP USS abdomen re: ?gallstones and an outpatient Holter monitor for her palpitations re: ?SVT*
- In the documented management plan:
  i. *Discharge home with simple analgesia and Mylanta*
  ii. *GP to organise USS abdo ?gallstones*
  iii. *If USS negative then GP to please start regular omeprazole 40mg po daily for 4/52*
  iv. *GP refer for outpatient Holter monitor*

Comment: There were clear and explicit recommendations contained in the ED discharge summary for [Ms A's] GP to organize outpatient abdominal ultrasound and cardiology referrals.

5. [Dr B] reviewed [Ms A] on 11 January 2019. Physical examination was unremarkable and [Ms A] was observed to be *feeling better today.* Documented management plan was: *Advised soft diet for few days, meds as given* [Buscopan tablets], *referral for USS abdomen, referral to Cardiology.* Weight (recorded by the practice nurse) was 74.5 kg (2.5kg decrease since December 2018) but there is no reference to [Ms A] complaining of weight loss.

Comment: [The medical centre's] response includes: *[Dr B's] usual practice is to arrange referrals while the patient is still in the consultation room, and once loaded on MedTech the referral remains active and visible whilst it is outstanding. [Dr B] deeply regrets and apologises to [Ms A] that the referral for an ultrasound was not done on that day.* [The medical centre] would be expected to have a policy in place for management of clinical correspondence and referrals,[1] including tracking of referrals and a copy of this policy should be obtained. (**A copy of the policy has been provided and reviewed. In my opinion, the policy is fit for purpose and consistent with similar policies I have**

[1] https://www.rnzcgp.org.nz/gpdocs/Foundation-Standards-Interpretation-Guide-APR-2016.pdf Accessed 1 September 2020

reviewed from other medical centres. Tracking of referrals (using Task manager) is at the discretion of the referrer but is recommended when significant pathology is suspected. Patients should be instructed when an appointment or response might be expected and to contact [the medical centre] if the appointment appears delayed.) However, many processes in relation to tracking of referrals rely on the referrer setting a task or reminder using the relevant PMS module once the referral is completed with there being more individual variation in practice as to how the referrer is reminded to complete the referral in the first place (eg paper note, electronic note). It appears [Dr B] usually completed the referral at the time of the consultation but may have been under some time pressure on this occasion. He did not apparently have an adequate process in place for recording tasks that required completion outside of the consultation and this led to the referral being overlooked. I am sure many of my colleagues have been in this same situation and the need for a robust task reminder system (separate to a referral tracking system) cannot be over-emphasised. It seems likely the referrals being overlooked on this occasion was the result of human error rather than a practice systems issue. However, accepted practice in the situation described is that the recommended referrals, for which there were sound clinical indications, were completed in a timely manner and [Dr B] failed to do this. This represents a moderate departure from accepted practice noting there was a recorded intention to complete the referrals. I recommend [Dr B] review/modify his current process for monitoring due or overdue tasks to ensure increased reliability.

6. [Ms A] was reviewed on 21 January and 18 February by [a doctor] in relation to ACC documentation for her left leg issue. There is no record of presentation of GI symptoms at these consultations but I note a referral was made for coeliac screen (normal) implying it is likely some symptoms were presented although notes record: *Bloods as per her request*. On 20 March 2019 [Ms A] saw [Dr B] for ACC documentation and repeat of her regular medications. Notes include: *Also still having low grade RUQ pain on and off … abd — generally soft, vague deep tenderness in RUQ. Imp — likely gallstones/biliary colic. Plan: referred for USS.* I could not see any record in the clinical notes of an Outbox referral document generated on this date.

Comment: [The medical centre's] response notes [Ms A] reported to [Dr B] that she had not received her ultrasound appointment, and [Dr B] sent a referral the same day. I have assumed there was open disclosure to [Ms A] regarding the delayed referrals and I would be concerned if there was not (**further response from [the medical centre] implies there was open disclosure**). The response includes: *the referral for abdominal ultrasound was declined by [the public hospital] on 20 March 2019 due to resource constraints within [the public hospital] and the direction was given for [Ms A's] GP to organise a scan in the private sector. The rejection of the referral made on 20 March 2019 by [the public hospital] was filed by [Dr B] with the patient's clinical records*. There is no copy of the initial referral or correspondence from [the hospital] on file and a copy of these documents should be obtained. (**The initial ultrasound referral has been reviewed and notes a history of right upper quadrant pain and *seen at [the hospital] last Dec for severe pain, recommended USS by GP.* There is a standard letter on file**

dated 20 March 2019 from [the hospital] radiology clearly outlining the process for making a community referral for the requested procedure as [the hospital] did not currently have capacity to undertake it.) Given the initial delays in the referral being made, I would expect [Dr B] to have been particularly conscientious in ensuring the ultrasound referral was confirmed. It is unclear why the rejected referral was filed without the recommended community radiology referral being completed but it is cause for concern if clinical correspondence was not being adequately reviewed at this time. The failure by [Dr B] to complete a community referral for [Ms A's] ultrasound on this occasion was at least a moderate departure from accepted practice noting [Ms A] continued to be symptomatic but an initial hospital referral had been completed although declined. It is not possible to state unequivocally that ultrasound in January or March would necessarily have altered [Ms A's] eventual management, but the investigation should have been undertaken as recommended in the ED summary and this was not done.

7. [Dr B] reviewed [Ms A] on 30 April 2019 in relation to her leg issue (under specialist care). There is no reference to complaint of GI symptoms or enquiry regarding the ultrasound appointment. On 13 May 2019 [Dr C] reviewed [Ms A] in relation to acute mental health issues and a back abscess. Surgical and mental health referrals were made. [Dr C] reviewed [Ms A] the next day (14 May 2019) and noted recent history of palpitations (referral made for cardiology review) and: *diarrhoea few months, gets urge, FIT test neg last yr. No rectal bleeding, no wt loss, nil upper GI Sxs, coeliac bloods n.* [Ms A] was referred for blood tests and outpatient colonoscopy. There is no reference to [Ms A] querying her ultrasound appointment. [Dr C] reviewed [Ms A] again on 20 May 2019 for several issues. Notes include: *Pt on P2 6wks for colonoscopy — arrange stool tests meantime as pt had come in with several p/p last week …* Referral was made for faeces microbiology and H pylori antigen testing. Investigation results showed normal faecal calprotectin, negative parasite PCR and H pylori antigen, normal CBC, liver function and iron studies.

Comment: [Dr C] was apparently reassured by [Ms A] she had had no significant weight loss. There was no history of rectal blood loss or iron deficiency. The history of persistent change in bowel pattern to looser or more frequent motions together with [Ms A's] age qualified her for direct access outpatient colonoscopy[2] (six-week wait category) and it was appropriate for [Dr C] to make referral for endoscopy. Appropriate initial investigations for diarrhoea were undertaken[3] and excluded inflammatory bowel disease, coeliac disease or infection as a likely cause. I am mildly critical there is no record of a rectal examination being offered or performed as part of the pre-referral assessment (as per recommendations in the cited HealthPathway). Noting diarrhoea was the predominant symptom, normal liver function tests and reference in the clinical notes to referral for abdominal ultrasound having been previously undertaken, I am not critical of [Dr C's] decision to refer for endoscopy rather than ultrasound. A copy of the

[2] https://www.health.govt.nz/publication/referral-criteria-direct-access-outpatient-colonoscopy-or-computed-tomography-colonography Accessed 1 September 2020
[3] HealthPathways 'Colorectal symptoms'

gastroenterology referral from May 2019 should be obtained and any histology reports from the colonoscopy should be obtained). (**The gastroenterology referral noted [Ms A's] history of persistent change in bowel pattern to looser more frequent motions and the absence of weight loss or rectal bleeding. I believe the referral was of adequate quality. Histology results were not provided to [the medical centre] but have been sourced by them and show the polyps to be tubular adenomas with low-grade dysplasia and mucosal sample normal (see s 9).**)

8. [Ms A] had several consultations with nurses (dressing changes for abscess) and a counsellor at [the medical centre] over the next month. She was reviewed by [Dr C] on 18 June 2019. Notes include: *trouble with diarrhoea, on 6 weeks W/L from 14/05, so another 2 weeks. Haematinics n, no rectal bleeding, no impr with buscopan prev, try loperamide short term only, stop prior to colonoscopy.* Loperamide and paracetamol prescribed. Next review with [Dr C] was 1 July 2019 when [Ms A's] diarrhoea was noted to be settling and colonoscopy due 15 July, but *has umbilical inf, d/c and epigastric pains couple of days, no vomiting, no fever, systemically well.* Abdomen was soft and non-tender and local umbilical infection diagnosed with omeprazole and Pimafucort cream prescribed.

Comment: [Dr C's] management of [Ms A] over this period was consistent with accepted practice noting colonoscopy was scheduled.

9. [Ms A] had blood pressure monitoring performed by the practice nurse on 4 and 10 July 2019 (readings currently elevated) and weight was recorded as 70.5kg on 10 July 2019. The same day [Dr C] noted: *diarrhoea resolved now, has appt Monday for colonoscopy, lost a lot of wt thru diarrhoea recent weeks >10kg, nil other concerns.* Colonoscopy report dated 15 July 2019 includes indication of: *Clinically significant intermittent diarrhoea of unexplained origin. Stool PCR negative. Calprotectin normal …* The colonoscopy showed mild non-bleeding haemorrhoids and three sessile polyps in the caecum (removed for histology). Mucosal samples were also taken from the colon. Management recommendation following the procedure was: *Await pathology results, repeat colonoscopy in 3 years (requested), trial regular Metamucil.*

Comment: I think it was reasonable for [Dr C] to attribute [Ms A's] weight loss to her diarrhoea and although the weight loss was a potential 'red flag' for malignancy, the appropriate investigation (colonoscopy) was imminent. It appears [Ms A's] diarrhoea symptom was settling and subsequent records show her weight stabilised at this point. The function of the colonoscopy was primarily to exclude colorectal malignancy (which was done) or occult inflammatory bowel disease (results of colon biopsy and polyp histology not on file but assumed to be normal). It appears the assessing gastroenterologist has made a provisional diagnosis of functional bowel disorder on the basis of the history presented in the referral and investigations to date (including colonoscopy) with trial of Metamucil recommended. I think this was a reasonable management strategy with the expectation that if the symptoms persisted or worsened despite treatment, or the clinical picture became more concerning (eg increasing abdominal pain, ongoing weight loss), the patient would be re-referred. With the

benefit of hindsight, [Ms A's] diarrhoea was most likely part of carcinoid syndrome related to her tumour. Carcinoid syndrome is most common in the setting of disseminated disease, particularly liver metastases. Symptoms commonly associated with the syndrome include diarrhoea (80 percent of patients), cutaneous flushing (85 percent), bronchospasm (10–20 percent) and venous telangiectasiae (late finding).[4] However, there is a broad differential diagnosis for aetiology of chronic diarrhoea with carcinoid syndrome being one of the less common causes.[5] I am not critical of [Dr C] or the gastroenterologist performing the colonoscopy for failing to consider carcinoid syndrome as a diagnosis at this stage.

10. [Dr C] reviewed [Ms A] on 16 July 2019 in relation to ACC certification, blood pressure review and new headache. Blood pressure medication was monitored and referral made for brain CT to exclude a vascular cause for the headache (performed 8 August 2019, normal). The colonoscopy the previous day is referred to as: *polyps removed, int hemorrh …* It is unclear if [Dr C] had reviewed the report at this point or if the information was conveyed by [Ms A]. [Dr C] reviewed [Ms A] next on 29 July 2019 noting her blood pressure had settled and *has had scope — hemorrhoids, for 3 years recall as per letter, nil other concerns.* Prescription for usual regular medications (including omeprazole) provided. There is no reference to discussion regarding, or provision of, the Metamucil recommended in the colonoscopy report.

11. Next review by [Dr C] was 13 August 2019 when brain CT results were discussed, blood pressure noted to be well controlled, ACC issues addressed, and *diarrhoea occasionally, no rectal bleeding, colonoscopy — hemorrh/polyps, nil malignancy etc.* No medication prescribed. Next review on 10 September 2019 was for ACC issues, blood pressure check and recurrent umbilical infection. There is no reference to ongoing GI symptoms. There was a further consultation on 9 October 2019 for urinary tract infection and musculoskeletal issues — again there is no reference to GI symptoms at this consultation. Weight was stable at 70.7kg.

Comment: I have assumed [Ms A's] diarrhoea symptom remained settled at this point other than occasional diarrhoea and there were no other concerning GI symptoms presented. [Ms A's] previous weight loss had stabilised and this was somewhat reassuring. It is unclear if the recommended trial of Metamucil was discussed but if [Ms A's] symptoms had settled it was reasonable to defer the trial. If she complained of persistent GI symptoms over this period, I would expect this to have been recorded in the notes and consideration given to review of results (which might have detected the overdue ultrasound) and possible re-referral for gastroenterology review and advice. However, I cannot state that such actions in August or September 2019 would have altered [Ms A's] subsequent clinical course or prognosis.

[4] Strosberg J. Clinical features of carcinoid syndrome. Up-to-date. Literature review current through July 2020. www.uptodate.com Accessed 1 September 2020

[5] Burgers K et al. Chronic Diarrhea in Adults: Evaluation and Differential Diagnosis. Am Fam Physician. 2020;101(8):472–480

12. [Dr C] next reviewed [Ms A] on 16 October 2019 in relation to insurance documentation and GI symptoms. Notes include: *Pt has biliary colic for some time — since Feb, nil USS done yet, was told it's done (referral), ref via proextra today please, hosp SOS if any worse, no fever, systemically well, gets b/colic after eating and intermittently since early this yr, has had colonoscopy nad …* Referral was made for community ultrasound which was completed on 18 October 2019 and showed multiple solid masses in the liver suspicious for metastases and also a right renal calculus. [Dr C] saw [Ms A] on 21 October 2019 to discuss the results noting: *Pt upset as she was d/c home from hosp January 2019 with abdominal pains, came to GP on 11 Jan 2019, was told she will be referred for USS. Documented also by that GP that sent USS abdo/cardiology. Pt did not receive any appt for USS. Pt had f/up 20/03/2019 with same GP re abdo pains RUQ. Referred for USS documented 20/03/2019 by GP. Pt tells me she did not receive any appt.* [Dr C] referred [Ms A] for urgent oncology assessment and the following day had a discussion with the oncologist resulting in [Ms A] being admitted to [the public hospital].

Comment: [Dr C's] management of [Ms A] was consistent with accepted practice.

13. [Public hospital] admission notes dated 22 October 2019 include history: *Unwell for last 1 year started with dry cough, epigastric pain ?biliary colic, for OP USS abdomen and palpitation for OP Holter in Jan this year when she was admitted to ED. Then no USS scan has been done, despite she is still getting intermittent epigastric and RUQ pain. She c/o has been complaining of alter bowel habit with diarrhea upto 4–5x/day +/- constipation at times when her usual bowel motion was normal form stool. She noticed the stool was floaty and smelly. Hence colonoscopy was done 15/7/19 which showe[d] Non-bleeding internal haemorrhoids and Three 3 to 4 mm polyps in the sigmoid colon, in the descending colon and in the transverse colon, removed with a cold snare. In addition, she has been having night sweat, unintentional weight loss of 10kg in the last 1 yr, nausea and vomiting 2–3x/wk in the last few weeks. No signs of GI bleed. Due to the ongoing intermittent Abdominal pain, GP organised USS abdomen and found to have multiple liver met hence she was sent to hospital …* [Ms A] underwent further investigations including staging CT scan (small bowel lesion noted — possible primary tumour) and liver biopsy (confirmed cancer to be a well-differentiated neuro-endocrine tumour) and she was commenced on palliative treatment with parenteral octreotide.

14. [The medical centre] [has] outlined actions since [Ms A's] complaint including:

- Internal review of [Ms A's] management and peer discussion of the conclusions
- Appointment of a full-time clinical lead and steps taken to moderate GPs' patient workloads
- Dedicated time for paperwork
- Peer agreement that any tasks to be undertaken will be recorded in writing and checked off at the end of the working day

These actions appear reasonable and appropriate. I recommend [Dr B] provide [Ms A] a written apology for his oversights."

Further advice

The following further expert advice was obtained from Dr Maplesden:

"I have reviewed the additional provider responses on file.

1. [Medical centre]

I note the remedial measures undertaken by [the medical centre] since [Ms A's] complaint and these should go some way towards reducing the risk of a similar incident in the future. Measures include:

- Increased clinical and administrative workforce
- Peer review/case study of the incident in question
- Random audits of clinical notes
- Regular staff meetings
- Increased staff pastoral support
- Allotted paperwork time
- Referrals to be done during the consultation where possible with robust task reminder system to be used when that is not possible
- Provision of remote access to clinical notes

I have no additional comments or any alteration to my original advice regarding the role [the medical centre] played in the events in question, although I note [Dr B's] reflection that there was a shortage of doctors at [the medical centre] around the time of the incident and work pressures may have played some role in his oversights.

2. [Dr C]

(i) [Dr C] was not [Ms A's] regular GP and the consultation of 13 May 2019 was the first time [Dr C] had seen [Ms A].

(ii) [Dr C] details the content of her discussions with [Ms A] regarding GI symptoms at various times. The response is consistent with the clinical notes but is not entirely consistent with [Ms A's] recollection of events. However, there is no new information provided that alters the comments in my original advice.

(iii) [Dr C] did not perform a DRE, or offer [Ms A] the examination, prior to referral for colonoscopy. Under the circumstances described in my original advice, I was mildly critical of this omission. [Dr C] questions my clinical reasoning for that criticism. My reasoning is that if a rectal mass is detected, the patient qualifies for urgent colonoscopy (within two weeks) as opposed to the 'six week' category based on her existing symptoms (colonoscopy was eventually performed eight weeks following referral). It is only with hindsight that it can be said performing a DRE would not have altered [Ms A's] clinical course, and I note DRE forms part of the recommended pre-referral (colonoscopy) process in local guidance for patients with colorectal symptoms,[6]

[6] Community HealthPathways. Colorectal Symptoms.

described as: *All patients presenting with persistent colorectal symptoms require a digital rectal examination (DRE). The DRE results are required for referral.* I therefore remain mildly critical of this omission.

3. [Dr B]

(i) [Dr B] did not refer [Ms A] for cardiological investigations at any of the consultations he undertook with her between January and April 2019 although there was a documented intention to do so at the consultation of 11 January 2019. This appears to have been overlooked together with the ultrasound referral. There was no apparent urgency for cardiology review ([Ms A's] heart symptoms had apparently improved at the time of this review), and [Ms A] did not present ongoing or worsening rhythm-related symptoms at her subsequent consultations with [Dr B] to prompt completion of the referral. Noting [Ms A] had an unremarkable resting ECG performed in ED in January 2019, assuming she did not report persistent or worsening palpitation symptoms to [Dr B] and taking into account local guidance for investigation and management of palpitations,[7] I am mildly critical that [Dr B] did not complete the referral for Holter monitoring as recommended in the ED discharge summary dated 10 January 2019. However, I note his intention to do so.

(ii) There were clinical staff shortages at the time of the incidents in question and these were beyond the control of [Dr B] and his employer. The practice services a high-needs population and it is not possible or ethical to deny services to that population. I believe it is very likely the pressures of work contributed to [Dr B's] oversights and he was not in a position to reduce his patient contact hours and increase paperwork time because of the staff shortages. I believe these factors should be considered when determining the response to [Dr B's] omissions, but the result of these omissions (delayed diagnosis of malignancy) should not be minimised.

(iii) There is no new information presented which alters the comments in my original advice."

[7] Community HealthPathways. Palpitations.

Appendix B: The medical centre's relevant policies

The medical centre's "Patient Test Results, Correspondence and Reports" policy that was applicable and relevant at the time of events stated:

"**Policy**

— [The medical centre] is committed to facilitating patient continuity of care by ensuring there is a documented process to effectively manage clinical correspondence, test results and other investigations.

— [The medical centre] is committed to implementing a patient's right to be advised of their test results particularly significant results.

…

Procedure

- All incoming test results are to be seen and actioned by the Doctor who ordered the test or referral for investigation.

- Items that arrive in Doctors Inbox along with x-rays and most specialist letters and hospitals discharge summaries need to be checked for clinically significant results and appropriate action arranged.

- When tests/investigations are ordered, patients will be advised how, when, and if they will be contacted about results.

…

Test Results Management Process

4	**Policy Resource: <u>Managing Patient Test Results — Minimising Error</u>** Tracking urgent referrals and significant pathology: — The task manager is set to track urgent referrals, radiology and any significant pathology, such as cytology and histology. — The Doctor or Nurse can also set up a task opportunistically for any significant tests. — Patients are also to be verbally reminded to let their Doctor know if they have not heard from the hospital/specialist within a certain time frame (3–4 weeks) if there is concern about the condition."

The medical centre provided an updated policy: "Management of Clinical Correspondence, Test Results and Other Investigations Policy and Process". The relevant clauses include:

"**Ordering Tests and Referrals**

— For urgent referrals/test results, imaging; a task is created in the PMS for follow up within 7 days. Ordering doctor can also create self-staff task to chase results within 7 days either via the health-link assign staff option OR staff task option on MedTech.

— For non-urgent referrals/test results, imaging; a task is created in the PMS for follow up within 14 days.

— Patients are advised to contact the practice if they have not heard from the referring hospital outpatient clinic/specialist within specified period for example — one to two weeks for urgent referral and within three to 4 weeks for non-urgent referrals.

— Patients who have been referred to the Public System can be given the phone number to ring Hospital reception to check themselves on the progress of their referral."

Appendix C: The medical centre's internal review

"Date: Friday 01 November 2019, 1 pm

Location: [The medical centre]

Present: [Two reviewers], [Dr B]

a) Written complaint received via email on 21 October 2019. Patient complained against [Dr B], concerned her ultrasound scan was not done earlier. This ultrasound scan has shown liver metastases.

b) Patient notes and consultations thoroughly reviewed and discussed.

c) Patient presented to ED on 10 January 2019 with epigastric pain and palpitations. Discharged after 3.5 hours once comfortable. Discharge to GP recommended an outpatient ultrasound ?gallstones, and referral for Holter monitor ?SVT.

d) Patient consulted with [Dr B] on 11 January 2019. Notes state symptoms had improved, RUQ and RIF pain on exam. Plan was referral for outpatient abdominal ultrasound and referral cardiology. However neither of these referrals were completed.

e) Patient consulted with [a doctor] 28 January 2019 and again 18 February 2019 — both times for ACC 18 extension. No mention about palpitations or abdominal pain in his notes.

f) Patient consulted with [Dr B] again on 20 March 2019. She presented for an ACC extension and reporting ongoing RUQ pain. [Dr B] suspected gallstones/biliary colic. He extended her ACC 18 and referred her via healthlink for an ultrasound.

g) Two letters, one being the original referral and the other, a letter from [the radiology service] were scanned onto the patient's file on 27 March 2019 with the information that the referral had been declined. It contained information and advice that all community ultrasounds are to be arranged through … Unfortunately this letter was filed without being acted upon.

h) Multiple consultations occurred since this consult until an ultrasound was arranged with: …

i) She was referred acutely to [the public hospital] for further workup. Has been diagnose[d] with Presumed small bowel (possibly ileum) Grade 2 neuroendocrine tumour, metastatic to liver with carcinoid syndrome.

j) In summary: [Dr B] did not refer for an ultrasound or to Cardiology in January 2019. He did refer for a scan in March but unfortunately instructions in the declined letter were not acted on.

k) [Dr B] has admitted his error and is remorseful. He is truly apologetic. During this time had a heavy workload as the clinic was down a doctor.

l) Importance of being diligent and upholding our duty of care to the highest standards for all patients emphasized.

m) [Dr B] agrees to implement a system to ensure that all referrals are acted on as soon as possible and kept a note of to avoid this in the future.

n) This case is to be discussed at peer review to ensure all doctors have a system in place. Also need to ensure the doctors feel supported and know to ask for help if feeling overwhelmed, overworked or burn out.

o) [Reviewer] to write a reply to the patient, offer a face to face meeting. Reply needs to also include details of HDC."