General Practitioner, Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 18HDC00740)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 17 August 2017, Mrs A visited a medical centre about her high blood pressure and bowel issues, including rectal bleeding. Mrs A was seen by general practitioner (GP) Dr B, who arranged a follow-up consultation to review Mrs A's bowel issues further. However, Dr B did not record Mrs A's bowel issues in the clinical notes.

2. Dr B ordered blood tests and an FOB test.[1] However, Dr B did not prepare appropriate paperwork for the FOB test, and Mrs A's faeces sample was discarded by the medical laboratory. Subsequently, Dr B realised that FOB tests are not recommended for patients with Mrs A's symptoms. However, Dr B neglected to communicate this information to Mrs A.

3. On 22 August 2017, Mrs A had her follow-up consultation with Dr B. Following the consultation, Dr B decided to refer Mrs A for a colonoscopy. However, Dr B omitted to set up the referral in Medtech.

4. Mrs A contacted the medical centre in late December 2017 and asked about her colonoscopy referral. Dr B then realised that she had not processed the referral. Dr B did not inform the management team of her omission, and did not complete a Learning Event form. In addition, Mrs A was not informed of the omission until she telephoned the practice again in early January 2018 to follow up on her previous call.

Findings

5. The Commissioner found that Dr B did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) for the following reasons:

   a) She did not order a CBC (complete blood count) test, and attempted to order an FOB test when it was not recommended for individuals presenting with Mrs A's symptoms.
   b) She did not perform a digital rectal examination at the consultation on 22 August 2018.
   c) She did not process Mrs A's colonoscopy referral in a timely manner.
   d) She did not inform Mrs A of the estimated waiting time for a colonoscopy appointment.
   e) She did not process Mrs A's referral in an appropriate manner once she became aware of her omission to set up the referral.

6. It was also found that Dr B failed to disclose to Mrs A immediately the omission to upload the referral and, accordingly, that Dr B breached Right 6(1) of the Code.

7. The following adverse comments were also made about Dr B:

   a) She did not complete the Learning Event form.
   b) She did not communicate to Mrs A why the FOB test was no longer needed.

[1] Faecal occult blood test.

c) She did not record Mrs A's bowel issues in the clinical notes following the first consultation.

8. The Commissioner found that the failings identified were matters of individual clinical judgement and practice, and that the medical centre had taken such steps as were reasonably practicable to prevent Dr B's errors. Accordingly, the medical centre did not breach the Code.

Recommendations

9. The Commissioner recommended that Dr B provide a written apology to Mrs A, arrange an independent audit of referrals she had instigated, and enter into a mentoring relationship with a general practitioner, to focus on the area of common malignancies, particularly bowel cancer.

Complaint and investigation

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

- *Whether the medical centre provided Mrs A with an appropriate standard of care from August 2017 to February 2018.*
- *Whether Dr B provided Mrs A with an appropriate standard of care from August 2017 to February 2018.*

11. This report is the opinion of the Commissioner.

12. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer
Dr B	GP
Medical centre	Provider

Also mentioned in this report:

Dr C	Clinical lead
Mr D	Managing director

13. Further information was received from the medical laboratory.

14. Expert advice was obtained from in-house vocationally registered general practitioner Dr David Maplesden, and is included as Appendix A.

Information gathered during investigation

Background

15. Mrs A, aged 59 years at the time of events, had been a regular patient at the medical centre[2] since early 2017. Her medical history included hypertension. Mrs A visited the medical centre on 17 August 2017 and 22 August 2017. This report concerns the care she received at those consultations, in particular the tests ordered, the examination performed, and the lack of clear communication.

17 August 2017 — first consultation

16. When Mrs A visited the medical centre on 17 August 2017, her regular general practitioner (GP) was on holiday, and an appointment was made for her to be seen by Dr B[3] at the medical centre's acute clinic.[4]

17. Dr B told HDC that at the end of the consultation, Mrs A raised issues with her bowels, including rectal bleeding. However, Mrs A told HDC that "bowel symptoms were discussed in the middle of the meeting, with time to spare". Mrs A said that she informed Dr B that the "bleeding was dark and mucousy and that [she] had been having some slight pain in [her] lower abdomen and lower back" and "sometimes bright red and fresh" bleeding. Due to time constraints, Dr B scheduled another appointment for 22 August 2017 to investigate Mrs A's rectal bleeding further.

18. At the end of the 17 August consultation, Dr B ordered blood tests for Mrs A, and gave her a laboratory form for the following tests: "Lipids Master Panel[5]; renal function panel[6]; thyroid function tests[7]; and glycated Haemoglobin[8] and iron studies[9] to check for blood loss and anaemia in the case of prolonged bleeding." Dr B also gave Mrs A "a container for a faeces sample for a faecal occult blood test"[10] (FOB test), but did not give her a laboratory form for this test. Dr B informed HDC that "the [rectal] bleeding that [Mrs A] had described to [her] indicated the possibility of bowel cancer". However, Mrs A told HDC: "[The possibility of bowel cancer] was not mentioned to me prior to 29 December."

[2] General practice primary healthcare provider.
[3] Dr B began her employment with the medical centre in 2017. Prior to this she worked for another general practice. Dr B had been in New Zealand for about 10 years, and prior to that had worked overseas as a GP.
[4] The acute clinic is integrated into the general practice. All patients can use it as a "walk-in" service if they feel that their medical or accident need is urgent and/or they cannot wait for their usual doctor.
[5] Measures the level of specific lipids (fats) in the blood to assess the risk of cardiovascular disease.
[6] Evaluates kidney function in patients with known risk factors (eg, hypertension, diabetes, obesity, family history of kidney disease).
[7] Assessment of the functioning of the thyroid gland.
[8] Measurement of the person's average blood glucose level over the previous two to three months.
[9] Measurement of the body's current store of iron.
[10] A test to detect the presence of haemoglobin in the faeces, which may indicate colorectal adenomas or cancers.

19. The Clinical Lead at the medical centre stated: "[U]sually an FBC (full blood count[11]) would also be ordered. The other blood tests ordered were appropriate in relation to [Mrs A's] blood pressure." Dr B informed HDC that "it is her usual practice to order a CBC[12]". However, from the clinical notes, she did not order a CBC at this visit.

20. Dr B did not record Mrs A's bowel issues or rectal bleeding in the clinical notes. Dr B told HDC:

> "I did not make any entry in the clinical notes relating to the bowel issue because I did not undertake a thorough examination on that day in relation to this issue. I did not provide [Mrs A] with the requisite separate laboratory form for the faecal (FOB) sample and I did not give her a prescription as well on that day which is my regular practice. This suggests to me that there may have been a problem with MedTech[13] at that time."

21. The medical centre told HDC that at the time of the consultation in August 2017 there were no technical issues with Medtech.

18 August 2017 — FOB test

22. On 18 August 2017, Mrs A went to the laboratory for her blood tests, and took with her a faeces sample for the FOB test. She was informed by laboratory staff that "there was only paperwork for the bloods but none relating to the stool sample". Mrs A said that she communicated with the medical centre regarding the paperwork issue, and expected that the medical centre, Dr B, and the laboratory would resolve this for her.

23. On the same day, a staff member at the laboratory rang the medical centre and spoke to one of the nurses. The nurse advised the laboratory to discard the faeces sample as it was not documented in the clinical notes. The nurse recorded in Mrs A's clinical notes: "[Patient] took in a faeces sample this morning with no form. I advised I can't see why she took that in, Dr only [requested] bloods. They will discard the sample."

22 August 2017 — second consultation

24. On 22 August 2017, Mrs A returned to the medical centre and saw Dr B as scheduled previously. At this consultation, Mrs A's rectal bleeding history was discussed in more detail, and Dr B examined Mrs A.

Discussion of FOB test

25. Mrs A said that Dr B informed her that her blood test results were normal, but she did not mention the FOB test. Mrs A told HDC: "Upon asking, [Dr B] replied they were thrown out because the Lab doesn't test them there … nothing was brought up at the time about the lack of paperwork."

[11] Measurement of the kinds and numbers of cells in the blood to check general health and to help diagnose and monitor a variety of conditions and treatments.
[12] Complete blood count — same as "FBC".
[13] Software to assist health professionals with patient management.

26. Dr B initially told HDC:

> "I was not aware in August 2017 that FOB testing is not undertaken within [the DHB] (FOB samples need to be sent outside of the region). I subsequently became aware that if doctors do not send the requisite form the laboratory will discard the specimen."

27. However, the laboratory informed HDC that up until 15 January 2018 it processed most FOB test requests in the local laboratory. It told HDC:

> "[H]ad we received a faecal sample and a request for tests, either on the blood form of the 18th/8/17 or indeed on a separate form on its own, it would have been entered into our LIS and subsequently reported back to the referrer."

28. The medical centre told HDC:

> "It is usual practice for the nurse if it was unclear (as in this case) to check with the ordering doctor … However, in this situation the stool test was actually unnecessary which [Dr B] discovered after she ordered the test. The local gastroenterologists have advised that if there is known visible rectal bleeding a stool test to check for faecal occult blood is not indicated and should not be done."

29. Subsequent to her initial response above, Dr B provided a similar explanation. She stated:

> "[O]n 18 August 2017, I became aware that local gastroenterologists have advised the medical centre that if there is known visible rectal bleeding a stool test to check for faecal occult blood is not indicated and should not be done."

30. However, at no time did Dr B contact Mrs A to explain why the FOB test was no longer needed. Dr B stated: "I regret I did not advise [Mrs A] of this and acknowledge that I should have done so and documented this in [Mrs A's] clinical records on the MedTech system." The medical centre apologised for the lack of communication by [Dr B] regarding this issue.

Rectal examination

31. Mrs A told HDC:

> "[Dr B] gloved her hand and placed it on my right bottom cheek, looked at my anus, and responded with 'no haemorrhoids'. At no stage did she perform an internal examination."

32. Dr B recorded in the clinical notes:

> "Has blood and mucus for (few months).
>
> Has dull ache in low abdomen, sometime before sometime after defecation, sometime no pain at all.
>
> Was hoping will improve but now after 3 months she decided to do something about that.

> Has regular bowel motions, NO constipation,
>
> blood in the stool, not only on toilet paper, and has mucus regularly.
>
> E [Examination]
>
> no haemorrhoids on PR examination[14]
>
> Abdo soft, nontender, no organomegaly[15]
>
> referral to gastroenterology."

33. Dr B told HDC:

> "My regular practice is to do a digital examination.[16] I do not do so only if the patient does not want this due to the discomfort associated with this examination.
>
> …
>
> I cannot recall whether I undertook a digital rectal examination though this was and is my usual practice (with the consent of the patient) for such a presentation."

Referral

34. Following the rectal examination, Dr B decided to refer Mrs A for a colonoscopy. However, Dr B omitted to set up the referral in MedTech, and it was not sent; nor did she create a task in MedTech to remind her to make the referral.

35. Dr B did not inform Mrs A of the expected timeframe for a response from the hospital regarding the referral. Dr B acknowledged that "she should have given [Mrs A] an indication of how long she was likely to have to wait after a referral for advice of an appointment".

December 2017 to January 2018 — realisation of omission, and subsequent action

28 December 2017

36. On 28 December 2017, Mrs A rang the medical centre about her referral. She was concerned that more than four months had elapsed since the referral, and she had not been contacted with an appointment date. Mrs A said that she asked the nurse to check whether the referral had been processed, and the nurse advised that she would check with the relevant doctor and telephone back that day.

37. Dr B stated: "[T]he nurse did speak to me [that day] … and it was then that I realised that I had not sent the promised referral." The nurse did not return Mrs A's call. The medical centre told HDC: "[T]he staff member who took the call communicated query to [Dr B] … This was in accordance with Clinic protocol."

[14] "Per rectum" examination (examination through the rectum to check for abnormalities).
[15] Abnormal enlargement of an organ.
[16] Insertion of a lubricated, gloved finger into the rectum to feel for abnormalities.

29 December 2017

38. Dr B said that she attempted to facilitate an urgent referral on 29 December 2017. However, when completing the referral form, Dr B copied the clinical notes of 22 August 2017 and pasted them into the details section of the referral form,[17] and did not mention the delay since August 2017 in processing the referral.

4 January 2018

39. On 4 January 2018, Mrs A rang the medical centre again to follow up on her previous call regarding the referral (28 December 2017), as she had not received any further communication from the medical centre since the call. Mrs A said that the medical centre staff advised her that the referral has been placed by telephone. She then asked when the referral had been processed. Mrs A told HDC: "[Staff] went silent, and then said, 'I'm sorry, it has only just been done'. Further discussion revealed that the referral was … processed on 29th December 2017." Mrs A said that she was very upset by this information, and sent a written complaint to the medical centre on the same day.

40. The medical centre said that on the same day, the customer service staff member who took the call sent a note to Mrs A's usual doctor and to Dr B. The medical centre stated:

> "[Mrs A's usual doctor] received further information about the sequence of events from customer service staff, and then when she understood what had happened called [Mrs A] directly. [Mrs A's usual doctor] made the clinical director of the practice aware of what had happened with respect to the referral having not gone out until 29 December. The clinical director made [the managing director] aware of the issues on the same day."

Explanation regarding omission

41. In relation to the failure to upload the referral to MedTech, Dr B stated:

> "[My] usual practice when a referral is indicated and [I am] not able to do this immediately (which is the norm) is for [me] to create a reminder task in MedTech to do the referral. Tasks appear in red and would be seen by anyone looking at a patient's clinical record until the task had been actioned. [I] failed to set a task and/or to action the referral in this case. The omission by [me] to track completion of the gastroenterology referral via the PMS task management system meant there were missed opportunities to detect that the referral was overdue. This was an unintended human error and one for which [I am] sincerely sorry."

42. Medical centre management told HDC that it was not aware of this omission until 4 January 2018, when Mrs A rang the medical centre again. When asked about the incident, the medical centre informed HDC:

> "[Dr B] completed the referral on 29th December 2017. [Dr B] did not communicate with [Mrs A] at this time and [Dr B] accepts that she should have done so on receiving the message and completing the referral letter. The management of the medical

[17] See paragraph 32 above (the same note was recorded in the referral form).

> centre had no knowledge of the issue at this stage. When [Dr B] became aware of the lack of a referral she did the referral but did not discuss it with any senior staff member. This is not what is expected of our medical staff in a situation like this … usual procedure at this time would be to complete a learning event form (which is [the medical centre's] version of an incident form)."

43. Dr B agreed that the medical centre management became aware of the referral delay on 4 January 2018. She said that she "should herself have notified management and sought their assistance on 28 December 2017 [but it] was New Year and many staff were on leave". She acknowledged that Mrs A had the right to effective communication, and that she (Dr B) should have updated Mrs A as soon as possible regarding the delay and omission to upload her referral onto the MedTech system.

Learning Event form

44. Following this incident, on 4 May 2018 the Clinical Lead of the medical centre discussed with Dr B the usual procedure for completing a Learning Event form. The medical centre said that had a form been completed, "this would have ensured that others in the practice were aware of what had occurred and could have made further efforts immediately to ensure an urgent assessment occurred". The medical centre stated that "on discussion with [Dr B] … she advised [the medical centre] she was unaware of this expectation". However, the medical centre advised HDC that "it is part of the orientation programme that [Dr B] was taken through when she joined the practice".

45. Dr B later confirmed to HDC the above discussion with the Clinical Lead of the medical centre, and explained that at the time of the incident she had been with the medical centre for only a few months, and initially she had focused on prioritising her knowledge of the clinical protocols essential for daily practice.

Subsequent events

46. Once the management team became aware of the delay in actioning Mrs A's referral, the medical centre strived to progress the referral urgently. Mrs A underwent a colonoscopy on 16 January 2018, and subsequently was diagnosed with cancer of the rectum.

47. On 22 January 2018, the medical centre director rang Mrs A to apologise for the delay in actioning her referral, and offered to meet with her. Mrs A asked for "time to digest the information that she had just received", and asked the director to call her back in a week's time. The director rang Mrs A back and offered to make her consultations with her doctor or nurse at the medical centre free of charge. The medical centre stated: "[Mrs A] was clearly in a very difficult situation and we needed to do all we could to make things going forward for her as easy as possible."

48. On 25 January 2018, Dr B sent an apology letter to Mrs A. The letter stated:

> "[W]ith regard to the delay in your referral for a colonoscopy I would like to sincerely apologise to you for the inadvertent delay by me in sending through the gastroenterology referral and for the mix up with the FOB sample. I am committed to

best practice in all of my work as a GP and I have reflected on what happened in this case to ensure that this never happens again. I am truly sorry."

Orientation and training provided by the medical centre

49. The medical centre's Orientation Programme for Doctors includes a MedTech training checklist. The checklist includes boxes for the trainer and the trainee to tick off to indicate what the trainee has been taught.

50. The medical centre stated:

> "[Our] approach to orientation, which [was] followed with [Dr B], is to provide a set of orientation forms and ask the doctor to read through them, identify those areas that they need to discuss and marking those items they are familiar with that don't need discussion."

51. The medical centre informed HDC that doctors who are new to New Zealand will receive more rigorous training, whilst doctors familiar with the New Zealand system and with MedTech will be trained only under the headings with which they are not familiar. The medical centre noted that Dr B was not new to the New Zealand healthcare system, and that she "had been working in General Practice in New Zealand for 18 months using the same clinical system as [the medical centre]".

52. The medical centre said that it "leave[s] the responsibility for the completion of the forms with the doctors, for them to tick off each item that they need covered as they spend time with whomever it is that is providing the orientation". The medical centre has been unable to locate a copy of the checklist completed by Dr B, and said that the checklist is "generally kept by the doctor and so it is possible that [Dr B] took it with her".

53. The medical centre stated that Dr B received formal supervision from another doctor, consisting of eight hours in the first month, three hours in the second month, two hours in the third month, and subsequently at least one hour per month.

Changes made since incident

54. The medical centre told HDC that as a result of this incident it identified areas for staff improvement, including:

a) Providing patients with an indication of how long they are likely to wait following a referral, before being advised of an appointment.

b) Doctors being required to notify management and seek assistance if they consider that they have made a mistake or omission and believe that a significant problem exists.

55. The medical centre also advised that it plans to "put the orientation forms for each new doctor up on [the medical centre's] intranet in a private folder for the 'new doctor' so that the new doctor can see his/her form and progress to date as can the doctor/manager who are providing the supervision".

56. Dr B told HDC that as a result of this incident she has made changes to her practice, including:

a) If she suspects malignancy, a referral is done immediately at the time of the consultation, with the patient in front of her.

b) She ensures that patients are given a timeframe for when they can expect to be seen on referral, and encourages them to follow up with the practice if there are any delays and/or there are any changes in their symptoms prior to being seen on referral.

c) Following discussion with her supervisor, her peers, and management, she is aware of the importance of communication skills, and is taking every opportunity to improve her communication skills.

Medical centre policies

57. The medical centre provided HDC with its policy paper regarding an "effective system for the management of clinical correspondence, test results and other investigations". The policy states:

> "There is a documented policy that describes how laboratory results, imaging, reports, investigations and clinical correspondence are tracked and managed.
>
> All incoming test results or other investigations are sighted and actioned by the team member who requested them or by a designated deputy.
>
> …
>
> 2. It is practice policy that a reminder of requested blood tests and x-rays and referral letters are automatically listed in the clinician's task manager using the Medtech tracking system. This enables tracking of potentially significant investigations/ referrals.
>
> …
>
> 8. Tracking of potentially significant investigations and urgent referrals — All standard pre-formatted referral documents in Med Tech, when used to send a referral, generate an automatic reminder to the Clinician's task manager …"

58. The medical centre's Incident Reporting policy states:

> "All incidents, including first aid injuries and near misses, at [the medical centre] must be reported. This is to enable appropriate investigation and responsive actions to be taken …
>
> Incident Form [online]
>
> - One staff member aware of the incident is to be responsible for generating the reporting procedure as soon as possible after the event as the more time that elapses the more difficult it is to recall the events clearly.

- Complete the form; include as much information as available in a clear and concise manner …"

59. The medical centre also adopts the Code of Health and Disability Services Consumers' Rights (the Code) into its policy, including Right 6 of the Code.[18] The policy states:

"• The Code of Health & Disability Services Consumers' Rights 1996 (The Code) is legal and binding on the practice and its staff. A copy of 'The Code' is attached (Appendix A) …

- Staff are trained to comply with The Code and to assist patients to access advocacy services …
- Compliance with [the] Code is expected of all staff."

Responses to provisional opinion

Mrs A

60. Mrs A was provided with an opportunity to comment on the "information gathered" section of the provisional report. Where relevant, changes have been made to the report to reflect her comments.

Dr B

61. Dr B was provided with an opportunity to comment on the provisional opinion. Dr B told HDC that she agrees with the findings and proposed recommendations. She said that her "learnings from this case include the need to ensure work life balance and to take regular breaks". She also advised that currently she is enrolled in the vocational training programme for General Practice, and from February 2019 has been working under supervision approved by the RNZCGP.[19]

Medical centre

62. The medical centre was provided with an opportunity to comment on the provisional opinion, and advised HDC that it considers that the opinion is "fair and reasonable", and said that it has no further comment to make.

Relevant standards

63. The requirement for doctors to keep clear and accurate clinical records is set out in the Medical Council of New Zealand's statement, "The maintenance and retention of patient records".[20] This states that doctors "must keep clear and accurate patient records that report relevant clinical findings; decisions made; information given to patients [and] any drugs or other treatment prescribed".

[18] Right to be Fully Informed.
[19] Royal New Zealand College of General Practitioners.
[20] Available from https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Maintenance-and-retention-of-records.pdf

64. The Ministry of Health's *Referral Criteria for Direct Access Outpatient Colonoscopy or CT Colonography* (updated November 2015)[21] states:

> "Use of faecal occult blood tests collected in asymptomatic individuals is not currently recommended in New Zealand (outside of the Waitemata District Health Board Bowel Screening Pilot) and should not be encouraged."

65. The Best Practice Advocacy Centre New Zealand *FOBT for Colorectal Cancer Detection*[22] states:

> "People with bowel symptoms suggestive of colorectal cancer, such as blood mixed with the stool, persistent change in bowel habit, abdominal pain or bloating and weight loss, should have an abdominal and rectal examination to rule out benign causes, followed by referral to a gastroenterologist if the symptoms are unexplained. FOBT is of little value, as a negative result does not exclude colorectal cancer … FOBT is not currently recommended as a population screening tool for colorectal cancer and the test's use in primary care is limited by several factors."

Opinion: Dr B

66. This opinion concerns the standard of care provided by Dr B to Mrs A in relation to her rectal condition. I am critical of some aspects of the care provided, particularly the tests that were ordered, the examination performed, and the lack of clear communication.

Standard of care — breach

Tests ordered

67. Following the consultation on 17 August 2017, Dr B gave Mrs A the requisite laboratory form for the following blood tests: "Lipids Master Panel; renal function panel; thyroid function tests; and glycated Haemoglobin and iron studies to check for blood loss and anaemia in the case of prolonged bleeding." Dr B noted that the tests were for Mrs A's bowel issues and high blood pressure. Dr B stated that it is her normal practice to order a CBC in this situation, but accepts that this was not recorded in her clinical notes or on the requisite laboratory form.

68. My in-house clinical advisor, GP Dr David Maplesden, is mildly critical that a CBC test was not ordered by Dr B. Similarly, the Clinical Lead at the medical centre stated that a full blood count (ie, a CBC) should have been ordered.

69. I agree with Dr Maplesden, and am critical that Dr B did not order a CBC test following the consultation on 17 August 2018.

[21] Available from http://apps.centralpho.org.nz/Permalink/MoM/General%20Documents/MoM/Published/Whanganui/Colorectal%20Cancer/referral-criteria-direct-access-outpatient-colonoscopy-ct-colonography-nov15.pdf
[22] Available from https://bpac.org.nz/Audits/colorectal-cancer.aspx

70. In addition to the blood tests, Dr B also attempted to order an FOB test. She provided Mrs A with a container for the stool sample, but failed to provide the appropriate documentation.

71. Dr Maplesden advised that an FOB is not an appropriate test for patients who exhibit signs of rectal cancer, as a negative result does not exclude colorectal cancer. The medical centre's Clinical Lead also advised that it is not expected practice to order an FOB test for a patient with rectal bleeding.

72. Dr B explained that she became aware that FOB tests are not recommended for patients with symptoms of rectal cancer only after she ordered the FOB test for Mrs A.

73. Dr Maplesden advised that the information regarding FOB tests and rectal bleeding and suspected bowel cancer was not new information, and had been available since 2009. The Ministry of Health and the Best Practice Advocacy Centre Guideline also provided this information prior to the time of the incident.[23] Dr Maplesden was "mildly critical [Dr B] was evidently not aware, in 2017, of the limitations of FOB testing in investigating suspected bowel cancer".

74. I agree with Dr Maplesden, and am critical that Dr B attempted to order an FOB test for Mrs A (although failed to provide the appropriate paperwork at the time) and was unaware that the test is not recommended for a patient presenting with Mrs A's symptoms. I am also concerned about Dr B's lack of awareness of the national guidelines for management of common symptoms of rectal cancer.

Digital rectal examination (DRE)

75. On 22 August 2017, Mrs A saw Dr B again to discuss her rectal bleeding and bowel issues further.

76. Mrs A stated that Dr B did not conduct an internal rectal examination, but placed a gloved hand on her right bottom cheek and looked only at her anus. Dr B stated that her regular practice is to perform a DRE, but she cannot recall whether she did so at this visit. She said that normally she would conduct a DRE only if a client consents to the examination. Her clinical note records, "No haemorrhoids on PR examination", but does not record whether an internal examination of the rectum was undertaken.

77. Dr Maplesden advised: "Provided a DRE was performed rather than just a visual anal inspection I would regard [Mrs A's] assessment as consistent with expected standards … I would be moderately critical if a DRE was not performed …" He said that the presence of a palpable mass on DRE would increase Mrs A's priority for colonoscopy.

78. Dr B cannot specifically recall whether she performed a DRE on this visit. I note that the clinical notes do not record that a DRE was performed, and there is no written record of any consent from Mrs A, despite Dr B's statement that she always sought a client's consent prior to undertaking a DRE. Mrs A's specific memory is that no internal

[23] See paragraphs 64 and 65.

examination of her rectum was performed at this appointment. Having considered all the information, I find it more likely than not that Dr B did not perform a DRE.

79. I am critical that Dr B did not perform a DRE at this consultation, as it may have provided useful information regarding the urgency of the colonoscopy referral subsequently made.

Delay in making referral

80. Following the visit on 22 August 2017, Dr B decided to refer Mrs A for a colonoscopy. However, Dr B did not set up the referral on MedTech immediately, and did not set a task management reminder. As a result, the referral was not processed until 29 December 2017, after Mrs A had called to follow up on the referral.

81. At the 22 August 2017 consultation, Dr B did not inform Mrs A of the expected timeframe for being contacted for her colonoscopy appointment. Dr B accepts that she should have done so.

82. Dr Maplesden advised:

> "I think the eventual three and a half month delay in [Mrs A] being seen for her colonoscopy … was a direct result of the failures by [Dr B] to complete the referral in a timely manner and track the referral, and to inform [Mrs A] of the expected time frame for her appointment. I feel this was the result of human error rather than any deficiency in practice processes … I believe the omissions discussed above represent at least a moderate departure from expected practice."

83. I am critical of Dr B's failure to inform Mrs A of the expected waiting time for an appointment, and of Dr B's failure to make the referral in a timely manner. Provision of this advice is important, as it enables patients to take an active role in their care, particularly in terms of knowing when to follow up if an appointment has not been received within the expected timeframe.

Processing of referral on 29 December 2017

84. As discussed above, Dr B processed the referral on 29 December 2017, when she realised that she had not done so following the consultation on 22 August 2017. In her referral letter, Dr B did not document any information regarding the delay in processing the referral.

85. Dr Maplesden advised:

> "The referral incorporates consultation notes from 22 August 2017 but does not identify these notes are by now five months old … There is nothing in the referral stating the intended referral date was August 2017, and nothing in the notes or responses to suggest that [Dr B] attempted to expedite the referral …"

86. I am critical that despite Dr B's statement that she attempted to facilitate an urgent referral, there is no evidence that she did anything other than process the referral on the MedTech system on 29 December 2017. Her referral did not document the delay in

processing or include any updated medical information, and did not request that the referral be expedited. It was only on 4 January 2018 — after the medical centre's management team became aware of Dr B's omission — that proper and urgent steps were taken to process and expedite the referral.

Conclusion

87. In summary, I consider that Dr B failed to provide appropriate care to Mrs A for the following reasons:

a) Dr B did not order a CBC test, and attempted to order an FOB test when it was not recommended for individuals presenting with Mrs A's symptoms.

b) Dr B did not perform a DRE at the consultation on 22 August 2018.

c) Dr B did not process Mrs A's colonoscopy referral in a timely manner, causing more than a four-month delay.

d) Dr B did not inform Mrs A of the estimated waiting time for a colonoscopy appointment, so that she could follow up if she had not received an appointment within that timeframe.

e) Dr B did not process Mrs A's referral in an appropriate manner once she became aware of the omission.

88. Taking into account these deficiencies, in my opinion Dr B did not provide services to Mrs A with reasonable care and skill, and I find that Dr B breached Right 4(1) of the Code.

Open disclosure to Mrs A regarding referral — breach

89. On 28 December 2017 — after Mrs A called to follow up on the colonoscopy referral — Dr B became aware that she had omitted to process the referral following Mrs A's consultation on 22 August 2017.

90. Dr B accepts that she did not inform Mrs A of the delay in processing the referral. Mrs A was informed that her referral had only just been processed when she rang the medical centre on 4 January 2018 to follow up. The disclosure was not made by Dr B, but by another staff member.

91. Dr Maplesden was critical of the delay in communicating to Mrs A the delay in processing the referral. He advised that "the responses indicate there was no open disclosure of the referral delay", and there was "poor communication" by Dr B.

92. I agree with Dr Maplesden, and note that the Medical Council of New Zealand also states that open disclosure should occur in a "timely manner". Right 6(1) of the Code provides that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. This right is also incorporated in the medical centre's policy. In my view, a reasonable consumer in Mrs A's circumstances — a consumer who had telephoned after almost four months to follow up on her referral relating to suspected bowel cancer — would expect to be told that the referral had yet to be made.

93. It took more than a week for Mrs A to be informed of the delay in processing the referral, and the disclosure occurred only after she contacted the medical centre for the second time. Further, it was not Dr B who advised Mrs A of the delay. Effective communication and open disclosure are vital to ensuring and maintaining a good relationship between a patient and a healthcare provider. The referral delay spanned more than three and a half months and, in my opinion, given the degree of the delay, Dr B should have disclosed the omission to Mrs A immediately. Therefore, for failing to inform Mrs A promptly about the delayed referral, Dr B breached Right 6(1) of the Code.

Learning Event form — adverse comment

94. The medical centre has a policy that following an adverse event, the Learning Event form must be completed by the practitioner with detailed information as to what happened, and the form must be provided to the management team.

95. Dr B did not complete the Learning Event form once she realised her error in failing to process the referral. She also did not advise any member of the management team. Dr B said that she was unaware of the policy and, as she was new to the medical centre, she was more focused on daily clinical protocols. The medical centre told HDC that its Learning Event form policy formed part of Dr B's orientation programme.

96. I am concerned that Dr B was not aware of the Learning Event form policy, and thus did not complete the form or advise management of her error promptly.

Communication to Mrs A regarding FOB test — adverse comment

97. On 18 August 2017, Mrs A went to the laboratory to have blood tests and an FOB test. However, she was advised by the laboratory that Dr B had not prepared the appropriate form for the FOB test. As a result, the laboratory did not conduct the FOB test for Mrs A. Mrs A told HDC that when she asked Dr B about the test, Dr B told her that the sample had been thrown out because the laboratory did not carry out FOB tests. Dr B said that she should have provided Mrs A with a proper explanation as to why the FOB test was no longer needed.

98. Dr Maplesden is "mildly critical that [Dr B] did not arrange for [Mrs A] to be informed in a timely manner that the FOB testing was no longer required".

99. I am critical that Dr B did not communicate to Mrs A why the FOB test was no longer needed.

Documentation — adverse comment

100. Mrs A said that she discussed her rectal bleeding and bowel issues with Dr B on 17 August 2017. Dr B accepts that she did not record Mrs A's bowel issues and rectal bleeding in the clinical notes, and explained that this was because she did not conduct a thorough examination of Mrs A's bowel issues on the day.

101. Dr Maplesden advised:

> "These symptoms and the management plan in relation to the symptoms should have been documented contemporaneously even if further assessment was deferred, and the failure to do this is a mild departure from expected standards of clinical documentation under this circumstance."

102. I am critical that Dr B did not record Mrs A's bowel issues in her clinical notes.

Opinion: Medical centre — no breach

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

104. The tests that should have been ordered, and whether or not a DRE should have been performed, were matters of clinical judgement for Dr B. Regarding the delayed referral, the medical centre had a system in place for the making and tracking of referrals, but in this case Dr B failed to use it, and did not set up a task management reminder. The medical centre also had in place a policy that required the completion of a Learning Event form for all incidents, but this was not followed by Dr B. The Code was also incorporated into the medical centre's policies. Prior to 4 January 2018, when Mrs A made a complaint, the management team was unaware of Dr B's omission. Once informed, the team attempted to progress Mrs A's referral urgently. On the same day, the medical centre contacted Mrs A by telephone regarding the issue.

105. Dr Maplesden advised:

> "[Mrs A's] subsequent management I believe was consistent with expected practice, as was management by the practice of issues arising from her complaint. I agree with the practice manager submission that the issues contributing to the delay in [Mrs A's] referral and poor communication regarding the delayed referral (once it was recognised) were primarily the result of individual human error rather than being a result of deficiencies in practice processes."

106. I consider that the errors that occurred did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

107. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994, an employing authority may be vicariously liable for acts or omissions by any employee. 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.

108. In August 2017, 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 order appropriate tests for Mrs A's rectal condition, failing to undertake a DRE examination at the 22 August 2017 consultation, failing to process the referral in a timely manner, failing to advise Mrs A of the expected waiting time for her appointment, and failing to process Mrs A's referral in an appropriate manner once Dr B realised her error.

109. I have also found that Dr B breached Right 6(1) of the Code, as, once she realised her mistake, she failed to disclose openly to Mrs A, in a timely manner, the failure to set up the referral.

110. As set out above, the tests that should have been ordered, and whether or not a DRE should have been performed, were matters of clinical judgement for Dr B. Regarding the delayed referral, the medical centre had in place a system for making and tracking referrals, but Dr B failed to use it, and did not set up a task management reminder.

111. Regarding the failure to disclose the delayed referral promptly, the medical centre had in place a policy that required the completion of a Learning Event form for all incidents. The Code was also incorporated into the medical centre's policies, and the principle of, and expectations around, open disclosure are contained in the Medical Council's guidelines. Dr B did not complete a Learning Event form in accordance with the policy, and did not inform Mrs A or the management team of her omission.

112. I also note Dr Mapleden's advice, as set out above.

113. Having considered the information provided by the parties, and Dr Maplesden's advice, I am satisfied that the medical centre had taken such steps as were reasonably practicable to prevent Dr B's errors. Accordingly, I do not consider the medical centre to be vicariously liable for Dr B's breaches of the Code.

Recommendations

114. I recommend that Dr B:

a) Provide a written apology to Mrs A for the breaches of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mrs A, by 29 July 2019.

b) Arrange an independent audit of 30 referrals to specialist secondary services that she has instigated in the last 12 months, to check that appropriate requests have been made and appropriate reminders put in place to follow up such referrals. The results of the audit are to be sent to HDC by 29 July 2019.

c) Enter into a mentoring relationship with a general practitioner appointed by the Royal New Zealand College of General Practitioners (RNZCGP) for six months from 1 July 2019. The mentor is to focus on the area of common malignancies, particularly bowel

cancer, and provide to RNZCGP and HDC, by 29 July 2019, written confirmation that the mentoring has occurred, together with the mentor's evaluation of Dr B's practice in the identified areas of concern.

Follow-up actions

115. 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.

116. 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 placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

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

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided to her by [Dr B] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the information on file: complaint from [Mrs A]; response from [Dr B]; response from managing director [medical centre], [Mr D]; response from clinical lead [medical centre], [Dr C]; clinical notes [the] DHB; comment from [the medical laboratory].

2. Complaint

(i) [Mrs A] complains about delays in the diagnosis of her rectal cancer in 2017. She states she developed intermittent painless rectal bleeding in May 2017 and this persisted and began to be associated with mild lower abdominal and back pain. She attended a consultation with [Dr B] on 17 August 2017 to discuss blood pressure issues and mentioned then about the rectal bleeding. [Dr B] advised blood tests and a stool sample and provided [Mrs A] with a lab form and pottle. She advised [Mrs A] to attend for review on 22 August 2017 at which point test results would be reviewed and a physical assessment undertaken.

(ii) [Mrs A] attended the lab on 18 August 2017 with her lab form and stool sample. She was told there was no lab form for the stool sample but blood tests were taken as per the form provided. [Mrs A] then contacted [the medical centre] and left a message stating paperwork was required for the stool sample to be processed.

(iii) At review by [Dr B] on 22 August 2017, [Mrs A] reiterated her history of rectal bleeding (dark blood with mucous, separate to the stool). She was told her blood test results were normal. There was no mention of the stool sample (which had been discarded by the lab in the absence of appropriate paperwork). [Dr B] examined [Mrs A] but performed only a visual inspection of the perianal area with no digital rectal examination (DRE) undertaken. [Mrs A] was informed she would require specialist review and that a referral would be sent for this.

(iv) [Mrs A] was unclear regarding the expected time frame for review. Her symptoms slowly worsened and on 28 December 2017 she contacted [the medical centre] to check the status of her referral. She was told contact would be made with her following discussion with the referring GP but she heard nothing back. On 4 January 2018 she again contacted [the medical centre] and eventually ascertained her referral had been sent on 29 December 2017 following her previous call, not in August 2017 as was intended.

(v) [Mrs A] subsequently underwent colonoscopy on 16 January 2018 and was diagnosed with a large rectal cancer palpable 5cm from the anal margin. She is

concerned that had [Dr B] performed a DRE in August 2017, the cancer might have been obvious then and resulted in more timely review. She is also concerned that the failure to perform the stool sample and cancer screening tests contributed to the delayed diagnosis, and that communication from [the medical centre] was poor in relation to the overdue referral.

3. Response [Dr B]

(i) [Dr B] noted that on 17 August 2017 [Mrs A] made an urgent appointment because she felt unwell and had measured high blood pressure readings on her home monitor. The blood pressure issue was addressed (blood tests ordered and medication prescribed) and towards the end of the consultation [Mrs A] presented an additional problem of three months of rectal bleeding. There was insufficient time to address the issue in detail so additional tests were ordered to check for anaemia and faecal occult blood (FOB). An appointment was scheduled for 22 August 2017 to review the blood results and further assess [Mrs A's] rectal blood loss. [Dr B] states she omitted to record any reference in the clinical notes to the discussion regarding bowel symptoms, and she omitted to provide a lab form for the FOB testing. When [Mrs A] rang and spoke with a practice nurse to discuss the FOB paperwork the nurse did not see any reference to bowel symptoms or FOB request in the clinical notes and assumed the sample had been provided in error. The lab was notified and discarded the sample.

(ii) At the consultation of 22 August 2017 [Dr B] rechecked [Mrs A's] blood pressure then discussed the bowel symptoms. Bowel motions were regular with no constipation but blood and mucous was present intermittently over the previous three months. *PR examination confirmed no haemorrhoids. Her abdomen was soft and non-tender and there was no organomegaly.* [Dr B] states her regular practice is to perform a DRE and she would not undertake this only if the patient refused consent. She does not explicitly state she performed a DRE on this occasion. [Dr B] states that on the basis of [Mrs A's] history and examination a referral was to be made for colonoscopy and FOB test was not required for this.

(iii) [Dr B] states: *Unfortunately I omitted to set up this referral on our Medtech software as a task and it was not done as it should have been on the 22 August 2017. [Mrs A] was advised to return for a blood pressure check in September 2017 but did not do so.*

(iv) On 28 December 2017 a nurse related to [Dr B] the call from [Mrs A] enquiring about her referral. [Dr B] then completed the referral which was sent on 29 December 2017. [Mrs A] was not notified of the outcome of her enquiry at this time. [Mrs A] was notified of the status of her referral only when she rang again on 4 January 2018 making further enquiries. She was seen for colonoscopy on 16 January 2018 and was referred on to a colorectal surgeon when her cancer was discovered on this date.

(v) [Dr B] apologises for the distress caused to [Mrs A]. She has altered her practice in that she now immediately completes any referral letters where malignancy is suspected and ensures that patients are given a time frame regarding expected

waiting time and what to do if the symptoms worsen. She is also more attentive to explaining the nature of investigations being ordered.

4. Response [Dr C]

(i) [Dr C] has reviewed [Mrs A's] complaint and management with [Dr B]. She notes the absence of clinical notes related to [Mrs A's] complaint of rectal bleeding on 17 August 2017 and that a full blood count was not ordered on this occasion. [Dr C] notes it is not expected practice to order FOBs in a patient with overt rectal bleeding and the discarding of the stool sample did not influence [Mrs A's] management. Unfortunately this was not communicated to [Mrs A].

(ii) The omission by [Dr B] to track completion of the gastroenterology referral via the PMS task management system meant there were missed opportunities to detect the referral was overdue. [Mrs A] was due for a blood pressure check in September 2017 but did not make an appointment for this. She requested a repeat of her blood pressure medication on 6 October 2017 and was notified by SMS message that she needed review by a doctor (in relation to her blood pressure) but did not make an appointment. [Dr C] notes that it would have been advantageous if [Mrs A] had been given some expectation of the likely wait for her appointment.

(iii) [Dr C] notes that [Dr B] did not instruct nursing staff to communicate with [Mrs A] regarding her referral enquiry on 28 December 2017, and the expectation would be for [Dr B] herself to have communicated with [Mrs A], notifying her of the oversight in completing the referral and the management plan going forward. The failure by [Dr B] to undertake this communication has been discussed with her, noting that staff are reminded of this responsibility at the time of their orientation.

(iv) Once other practice staff became aware of the issue with delay of [Mrs A's] referral, significant effort was made to communicate the situation directly with secondary care staff resulting in a very prompt appointment for [Mrs A's] colonoscopy.

5. Response [Mr D]

(i) [Mr D] notes there has been a comprehensive review of [Mrs A's] complaint. Supervision and orientation processes are outlined and these appear robust and consistent with expected practice. The attempts made to expedite [Mrs A's] colonoscopy are outlined, including the possibility of private colonoscopy paid for by the practice.

(ii) [Mr D] notes the practice's expectations with regard to management of referrals, use of the PMS task management function, communication of results and documentation of clinical queries. The practice also has a structured approach to coordinating referrals with one staff member tracking referrals against expected action time and ensuring the referrer is notified once the referral is accepted or rejected. I have reviewed the practice policy for management of results and clinical

correspondence and it is robust and consistent with expected standards for a 'Cornerstone' accredited practice (RNZCGP 'Aiming for Excellence' Indicator 23[1]).

(iii) Practice staff have been reminded of protocols regarding laboratory queries. Clinical staff have been reminded of the importance of providing patients with expected time frames regarding referral responses at the time the referral is agreed, and the need to involve management if a significant management error or omission becomes apparent. The practice has a formal event notification process.

6. Clinical notes review and comments

(i) Notes are consistent with the responses. There is no reference to [Mrs A] complaining of bowel symptoms until the consultation of 22 August 2017. [Mrs A] had been seen for a respiratory tract infection on 23 February 2017 and 7 June 2017.

(ii) Notes for the consultation of 17 August 2017 refer only to [Mrs A] feeling unwell with blood pressures of 176/116 and 157/103 recorded at home. The only assessment finding recorded is blood pressure of 175/95. Notes include: *Agree to start medication, blood test to exclude kidney damage with longstanding high BP, follow up in 1/12.* A prescription was provided for quinapril 10mg daily and laboratory form for creatinine, electrolytes, lipids, thyroid function, HbA1c and ferritin levels.

Comment: [Mrs A] had evidently had elevated blood pressure recorded on occasions in the past but had not commenced treatment. A more complete cardiovascular assessment might have been expected on this occasion (eg heart and lung auscultation, pulse rate) but management otherwise I think was consistent with accepted practice. [Mrs A] also presented symptoms of rectal bleeding at this consultation. These symptoms and the management plan in relation to the symptoms should have been documented contemporaneously even if further assessment was deferred, and the failure to do this is a mild departure from expected standards of clinical documentation under the circumstances. I think it was very reasonable to defer a full assessment for a few days to allow adequate time for the assessment and review of preliminary results, and an appointment was evidently scheduled for this. I am mildly to moderately critical that ferritin alone without CBC was requested as part of the lab assessment of rectal bleeding. Ferritin is an inflammatory marker and can be normal in the face of iron deficiency anaemia, and CBC (haemoglobin and red cell parameters) is used in national guidelines for direct access to outpatient colonoscopy[2] and the 'high suspicion of cancer' referral pathway[3]. Faecal occult blood tests have not been recommended for investigation of people with symptoms suspicious for bowel cancer for several years. A BPAC recommendation[4] includes: *People with bowel*

[1] https://oldgp16.rnzcgp.org.nz/assets/New-website/Quality/Aiming-for-Excellence-20-Sept-2016-FINAL.pdf#page=87 Accessed 12 June 2018
[2] https://www.health.govt.nz/about-ministry/leadership-ministry/expert-groups/national-bowel-cancer-working-group/national-bowel-cancer-working-group-documents Accessed 12 June 2018
[3] https://nsfl.health.govt.nz/system/files/documents/publications/high_suspicion_of_cancer_definitions_0.pdf Accessed 12 June 2018
[4] https://bpac.org.nz/Audits/colorectal-cancer.aspx Accessed 12 June 2018

symptoms suggestive of colorectal cancer, such as blood mixed with the stool, persistent change in bowel habit, abdominal pain or bloating and weight loss, should have an abdominal and rectal examination to rule out benign causes, followed by referral to a gastroenterologist if the symptoms are unexplained. FOBT is of little value, as a negative result does not exclude colorectal cancer. The use of tumour markers ('cancer tests') is generally not recommended in primary care because the majority of tumour markers (eg. CEA, CA19-9) are neither specific nor sensitive enough for use in the diagnosis of malignancy. The main use for tumour markers is in monitoring disease progression, treatment or recurrence of a histologically diagnosed cancer[5]. The exceptions to this are use of PSA as an adjunct to prostate cancer diagnosis and CA125 as part of investigation of suspected ovarian cancer.

(iii) Notes for the consultation of 22 August 2017 include blood pressure review (BP 165/100) and discussion that no change in therapy is warranted currently. In relation to bowel symptoms, notes include: *has blood and mucus for 3/12, has dull ache in abdomen some time before, some time after defecation, sometime no pain at all. Was hoping will improve, but now after 3 months she has decided to do something about that. Has regular bowel motions, no constipation. Blood in the stool, not only on toilet paper, and has mucus regularly. E: No haemorrhoids on PR examination. Abdo soft, non-tender, no organomegaly. Referral to gastroenterology.*

Comment: The documented history is adequate although best practice would be to determine any significant family history of bowel cancer (no family history noted on later hospital reports) and presence/absence of unexplained weight loss. Provided a DRE was performed rather than just a visual anal inspection I would regard [Mrs A's] assessment as consistent with expected standards. The presence of a palpable mass on DRE would increase [Mrs A's] priority for colonoscopy (see references 2 and 3). I note [Mrs A's] tumour in January 2018 was palpable 5cm from the anal margin (probably detectable on DRE). However, given the five month interval between examinations, I cannot predict the tumour would or should have been palpable via DRE on 22 August 2017. I would be moderately critical if a DRE was not performed by [Dr B] on 22 August 2017, although I acknowledge she had already made a decision to refer [Mrs A] for colonoscopy. Management (by way of referral for colonoscopy) was appropriate. Assuming the DRE was negative, [Mrs A] satisfied the criteria for colonoscopy within six weeks (there may be some variation between DHBs) and I believe she should have been advised to expect an appointment within this time frame, and I am mildly critical such information was not provided.

(iv) [Dr B] clearly had an intention to refer [Mrs A] for colonoscopy on 22 August 2017 but as a result of human error (omitting to follow the usual practice process for tracking and generation of referrals) completion of the referral was overlooked. The fact the practice task management system was not used, and [Mrs A] was not provided with a time frame within which to expect response to the referral, I think

[5] http://www.heftpathology.com/Clinical-Chemistry-Clinical-Advice/tumour-marker-use-in-primary-care.html Accessed 12 June 2018

were the main reasons for the omission not being detected in a timely manner. [Mrs A] had been advised to come in for review of her blood pressure in September 2017 but as this was within the expected time frame for a response to the referral it cannot be assumed that had she kept this appointment the referral issue would have been raised at all — particularly if she was seeing her usual GP rather than [Dr B]. On 9 October 2017 [Mrs A] phoned requesting a repeat of a regular medication (escitalopram) with nurse recording *needs seen for more SSRI — txt sent.* No prescription was provided and [Mrs A] did not make an appointment for review, although quite reasonably she did not feel there had been any undue delay in response to the gastroenterology referral at this stage (seven weeks since referral had presumably been sent) based on her experience with previous DHB referrals.

Comment: I think the eventual three and a half month delay in [Mrs A] being seen for her colonoscopy (assuming she would have waited about six weeks from 22 August 2017 for the appointment had the referral been sent at that time) was a direct result of the failures by [Dr B] to complete the referral in a timely manner and track the referral, and to inform [Mrs A] of the expected time frame for her appointment. I feel this was the result of human error rather than any deficiency in practice processes. I acknowledge [Dr B] had an intent to refer, and GPs are not exempt from human error. However, I believe the omissions discussed above represent at least a moderate departure from expected practice, that expectation being timely completion of a referral, tracking of a referral made for suspected malignancy, and informing the patient of the expected time frame for referral response.

(v) Subsequent notes are consistent with the responses. In relation to [Mrs A's] enquiry of 28 December 2017, the only documentation is a record of a patient referral being generated on 29 December 2017 (ie no specific record of her enquiry or the outcome of that enquiry). The referral incorporates consultation notes from 22 August 2017 but does not identify these notes are by now five months old (ie now an eight month history of rectal bleeding). Ferritin level was attached (normal) but as discussed previously, this did not entirely exclude the possibility of an iron deficiency anaemia (although subsequent blood count was normal). There is nothing in the referral stating the intended referral date was August 2017, and nothing in the notes or responses to suggest [Dr B] attempted to expedite the referral given the unintentional delay to date. The responses indicate there was no open disclosure of the referral delay. Taking all of these factors into account (poor documentation, failure to expedite the referral, poor communication, lack of open disclosure), I believe [Dr B's] management of [Mrs A's] enquiry regarding lack of response to the referral represents a moderate departure from expected standards of care. It is apparent her management of the enquiry was not consistent with the process expected by the practice.

(vi) [Mrs A's] subsequent management I believe was consistent with expected practice, as was management by the practice of issues arising from her complaint. I agree with the practice manager submission that the issues contributing to the delay in [Mrs A's] referral and poor communication regarding the delayed referral (once it was recognised) were primarily the result of individual human error rather than being

a result of deficiencies in practice processes. Recording of the history of possible irritable bowel syndrome has been accurately explained by [Dr C] and as rectal bleeding is not a characteristic of irritable bowel syndrome, recording of that history would not have any impact on triaging of [Mrs A's] colonoscopy request.

7. [Mrs A] had her colonoscopy on 16 January 2018. Notes include digital rectal examination revealed a firm rectal mass palpated 5.0cm from the anal verge. The mass was non-circumferential. Colonoscopy showed polyps in the ascending colon and caecum with a fungating non-obstructing large mass found in the rectum. Biopsy of the rectal tumour confirmed moderately differentiated adenocarcinoma and staging showed suspicious mesorectal nodes but no distant metastases. [Mrs A] underwent neo-adjuvant chemo-radiation which was ongoing at the time of her complaint. I wish her well with her recovery."

The following further expert advice was obtained from Dr Maplesden:

"I have reviewed further information received from [the medical centre] — letter dated 8 February 2018, and further response from [Dr B] dated 12 February 2019. Comments below should be read in conjunction with my original advice dated 18 June 2018.

1. I have reviewed [the medical centre's] policy on management of patient test results. This policy is fit for purpose and consistent with accepted practice.

2. I have reviewed the orientation framework used by [the medical centre] (including Medtech orientation) and, if applied as intended, this framework appears very adequate for the purposes of orientating clinicians new to NZ general practice. I note [Dr B] was not new to the NZ health system, and she had used Medtech for at least 18 months prior to her employment at [the medical centre]. The degree of supervision of [Dr B] as outlined in the [medical centre's] responses appears appropriate for her level of experience and was consistent with accepted practice.

4. [Dr B's] response

(i) Absence of documentation on 17 August 2017 regarding the bowel symptoms [Mrs A] presented at this consultation: no relevant new information presented and my original comments remain unchanged.

(ii) [Dr B] states she became aware, after recommending [Mrs A] have FOB testing undertaken, that local gastroenterologists have advised [the medical centre] that if there is known visible rectal bleeding a stool test to check for faecal occult blood is not indicated and should not be done. As noted in my original advice, national guidelines in 2009 and subsequently recommended against the use of FOBs in the investigation of patients with rectal bleeding and suspected bowel cancer. This was not new information in 2017. I am mildly critical [Dr B] was evidently not aware, in 2017, of the limitations of FOB testing in investigating suspected bowel cancer. Had there been any indication [Dr B] was waiting for a positive FOB result before considering referring

[Mrs A] for colonoscopy I would be somewhat more critical of her management. However, clinical notes suggest the referral was to proceed irrespective of the FOB result.

(iii) I am mildly critical that [Dr B] did not arrange for [Mrs A] to be informed in a timely manner that the FOB testing was no longer required.

(iv) The response from [Dr B] does not address the issue of her failure to order a CBC on 17 August 2017 (when multiple other blood tests including ferritin were ordered) as part of the 'work-up' of [Mrs A's] rectal bleeding and other bowel symptoms. I remain mildly to moderately critical of this oversight which, when combined with the intention to order FOBs, might raise some concerns regarding [Dr B's] awareness of national guidelines for management of common malignancies, or her clinical reasoning in this case.

(v) [Dr B] does not confirm she performed a digital rectal examination (DRE) on [Mrs A] on 22 August 2017 but states it is her usual practice to do so. [Mrs A] recalls an anal inspection being undertaken but no DRE. I am unable to confirm that a DRE took place and my original comments in this regard remain unchanged. The fact [Mrs A's] tumour was apparently easily palpable on DRE in January 2018 does not necessarily imply [Dr B] did not perform a DRE in August 2017 given the interval between the examinations (tumour growth) and different capabilities (finger length) of the examiners.

(vi) There is no relevant new information provided to alter my previously expressed view that the failure by [Dr B] to complete a timely referral, the failure by her to openly disclose (in a timely manner) to [Mrs A] that the referral had been delayed, the failure to document in the clinical notes that the referral was delayed, and the failure to update the referral in relation to duration of symptoms and the unintentional delay in referral, represent moderate departures from accepted practice. I note [the medical centre's] response states there was no issue with Medtech on 17 August 2017. I have no further comments or recommendations."