General Practitioner, Dr A
Medical Centre

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC01773)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a general practitioner (GP) to a woman between 2015 and 2018, and her delayed diagnosis of bowel cancer.

2. The report highlights the need to ensure that tests are followed up, and follow-up appointments made, to support timely diagnosis. It also emphasises the importance of using critical thinking to reassess diagnoses when symptoms change.

Findings

3. The Deputy Commissioner found the GP in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that the GP missed opportunities in 2016 and 2017 to refer the woman for a lower GI endoscopy, and this led to a delay in the woman receiving a diagnosis and treatment for bowel cancer. The GP failed to recognise unexplained iron deficiency on a number of occasions, and did not examine the woman's abdomen, perform a rectal examination, order repeat blood tests, follow up on stool and blood tests not completed, and make a referral for endoscopy.

4. Regarding another GP, the Deputy Commissioner highlighted the importance of clearly documenting safety-netting advice and abdominal examinations performed.

Recommendations

5. The Deputy Commissioner recommended that the GP review the RACP presentation[1] on cognitive factors in diagnosis and report back to HDC on his reflections, and provide a written apology to the woman's family.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his wife, Mrs B, by Dr A and a medical centre. The following issues were identified for investigation:

- *Whether the medical centre provided Mrs B with an appropriate standard of care between 2015 and 2018 (inclusive).*
- *Whether Dr A provided Mrs B with an appropriate standard of care between 2015 and 2018 (inclusive).*

[1] https://www.racp.edu.au/docs/default-source/Events/congress-2017-presentations/racp-17-tue-scott-heslop.pdf?sfvrsn=2 Accessed 9 July 2020.

7. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

8. The parties directly involved in the investigation were:

Dr A	General practitioner (GP)/provider
Mr B	Complainant/consumer's husband
Medical centre	GP practice/provider

9. Also mentioned in this report:

Dr F	GP

10. Further information was received from Dr C, a district health board (DHB), Dr D, and Dr E.

11. In-house clinical advice was obtained from GP Dr David Maplesden (Appendix A).

Information gathered during investigation

Background

12. This report concerns the delayed diagnosis of Mrs B's bowel cancer.[2] She was seen by Dr A and other GPs at the medical centre and by a number of specialists at the DHB[3] from 2015 to 2018. Dr A had been Mrs B's registered GP since 2012.

13. Mrs B, aged in her thirties at the time of events, had a complex medical history, including severe asthma (with a history of steroid dependency), osteoporosis,[4] allergies, hidradenitis suppurativa,[5] anxiety, depression, blood clots in the veins,[6] essential thrombo-cythaemia,[7] mechanical back pain, and haemorrhoids.[8] She also had a history of personal trauma. In 2007, Mrs B had an incision and drainage of a perianal abscess,[9] and in 2013 she was treated for a blood clot in a haemorrhoidal vein.[10]

[2] Also known as colorectal cancer.
[3] Dermatology, respiratory, haematology.
[4] Brittle bones.
[5] A chronic skin condition featuring lumps in places such as the armpits or groin.
[6] Venous thromboembolism (DVT).
[7] The body produces too many platelets, which can cause abnormal blood clotting or bleeding.
[8] Swollen and inflamed veins in the rectum and anus that cause discomfort and bleeding.
[9] A collection of pus under the skin next to the anal canal.
[10] Thrombosed external haemorrhoid.

2015

14. In late 2015, Mrs B had rectal bleeding and weight loss, and was iron deficient. During part of 2015, Dr A was away on extended leave, and Dr C saw Mrs B at the medical centre in April, August, and November 2015.

15. On 12 October 2015, rheumatologist Dr E saw Mrs B at the DHB. The clinic letter was sent to the medical centre, and stated:

> "[Mrs B] tells me she has lost 35 kilograms in weight over the last year. This has been looked into and attributed to prednisone reduction and perhaps her chronic infection related to her hidradenitis. There has been no change in bowel habit or fevers or night sweats."

16. On 21 October 2015, Dr E wrote another letter to the medical centre after having received Mrs B's blood test results. Dr E noted that Mrs B was iron deficient, and recommended she be reassessed with a view to "a referral to the Gastroenterologists for upper and lower GI[11] endoscopy[12] unless there are very good explanations for both her iron deficiency and weight loss". The medical centre received the letter on 29 October 2015, and on 2 November 2015 followed up with Mrs B and made an appointment for her to see a GP.

17. On 10 November 2015, Dr C saw Mrs B, who reported rectal bleeding that was thought to be consistent with haemorrhoids. Her bowel habit was alternating between constipation and diarrhoea. The weight loss reported in this consultation was 25kg over 12 to 18 months, which was thought to be due to her steroid reduction, multiple family bereavements, and ongoing infections with hidradenitis. Her weight was recorded as 71kg.

18. Dr C performed a rectal examination and recorded in the notes: "[N]o external piles, swelling internally." She told HDC that she also performed an abdominal examination, which was normal, and explained to Mrs B that she would need to come back if her rectal bleeding persisted, although Dr C did not document this. Dr C acknowledged that her documentation could have been more extensive.

19. Dr C said that she did not enquire about a family history of bowel cancer, as this was her first consultation with Mrs B, and she planned to follow up on the iron deficiency. Dr C stated that if Mrs B had returned with ongoing rectal bleeding, she would have asked about a family history of bowel cancer.

20. A message was left with nurses to contact Mrs B, with the comment:

> "[Mrs B] should still come in to be reviewed regarding the iron deficiency, but I think we should wait until one month after her operation (for excision of hidradenitis suppurativa lesions) and retest her iron then."

[11] Gastrointestinal.
[12] A procedure in which an instrument is introduced into the body to give a view of its internal parts.

21. A nurse communicated with Mrs B on 12 November 2015.

22. A letter to the medical centre from the Haematology Department at the DHB, dated 10 November 2015, stated that Mrs B's weight loss, night sweats, and hot flushes could be due to a type of blood cancer,[13] and noted that "her bowels fluctuate but are normal for her". Another letter on 16 November 2015 stated that it was suspected that Mrs B's iron deficiency was dietary, but it was queried whether it might be related to her steroid[14] or etidronate[15] use causing stomach inflammation.[16] The recommendation was for iron supplementation and referral to the Gastroenterology Department at the DHB if there was an inadequate response.

23. In December 2015, a diagnosis of essential thrombocythaemia[7] was confirmed by Haematology. The haematologist recommended a referral to Gastroenterology in two to three months if Mrs B did not have a satisfactory response to the iron supplementation she had started taking.

2016

24. Mrs B had ongoing reviews by Rheumatology, Dermatology, Respiratory, and Haematology clinicians, three- to four-monthly blood tests to monitor her platelet count, and prescriptions for iron, and she attended the medical centre for ongoing treatment of other unrelated matters. On 11 February 2016, a recall letter and blood test form were sent to Mrs B.

25. On 15 March 2016, Dr A ordered blood tests for Mrs B and re-prescribed iron supplementation. He said that he did not follow up on the blood test result as there was no change in Mrs B's iron level,[17] she had not reported any further rectal bleeding, and there were ongoing clinical causes for the low iron storage (heavy menstrual bleeding[18] and hidradenitis suppurativa).

26. In June 2016, a haematologist referred Mrs B to the Gastroenterology Department for upper GI endoscopy,[19] but this was declined. A rheumatologist made a re-referral in July 2016, but this was also declined.

27. Dr D, the Clinical Director of the Gastroenterology Department at the DHB, told HDC that the first referral was to exclude malabsorption, and with no evidence of anaemia or localising gastrointestinal symptoms reported, the referral for gastroscopy[20] was not accepted in line with the DHB criteria for gastroscopy. Dr D stated that the second referral was to determine the safety of using non-steroidal anti-inflammatory drugs in the presence of unexplained iron deficiency, and was also declined as "there is no evidence to support

[13] Myelofibrosis.
[14] Prednisone.
[15] A bisphosphonate medication for treating osteoporosis.
[16] Gastritis.
[17] Haemoglobin or ferritin level.
[18] Menorrhagia.
[19] A lower GI endoscopy was not requested at this time.
[20] A procedure to examine the upper part of the digestive system.

routine gastroscopy in individuals requiring anti-inflammatories in whom no new symptoms or complications have occurred".

28. On 14 September 2016, the haematologist wrote advising that he had asked Mrs B to double her iron supplementation.

Consultation with Dr A 27 April 2017

29. On 27 April 2017, Mrs B saw Dr A to discuss proposed back surgery and pain relief, and her hidradenitis symptoms were discussed. Dr A told HDC:

> "At the end of this consultation [Mrs B] mentioned her irregular bowel habit … I had been aware that she [had had] intermittent abdominal pains over many years with alternating constipation and diarrhoea. She did not mention any associated PR[21] blood loss. The chronology that she described to me was of several years of irregular bowel habit with episodes of pain going back prior to her last pregnancy."

30. Dr A did not examine Mrs B's abdomen.

31. Records show that Dr A advised initial treatment for irritable bowel syndrome, and, if there was no satisfactory response to the IBS treatment, further blood and stool tests and possibly gastroenterology review. Dr A told HDC that he "would have asked about rectal bleeding in the context of [Mrs B's] bowel symptoms", and stated that if Mrs B had had rectal bleeding at the time, he would have sought testing[22] and referred her to colorectal/general surgery.

Consultation with Dr A 7 June 2017

32. On 7 June 2017, Mrs B was reviewed by Dr A. She was distressed, and Dr A said that options for managing her anxiety were discussed. She reported bowel symptoms, and Dr A recorded in the notes:

> "[O]ften has urgent bowel action in morning — occ[uring] 4–5 times — will wake at night with bad abdo pain and then has loose bowel motion/green water and offensive smell.
> no clear pattern — [Bowels open] — 20–30 times per day
> occ passes blood and mucus as gets mucus discharge
> feels very bloated — no obvious food precipitants ie dairy/gluten
> symptoms over past 2 years but worse past 2–3 m[onths]
> amitriptyline has helped sleep but not bowel habit."

33. Dr A told HDC that Mrs B did not have any abnormal weight loss or loss of appetite, and the pattern of outlet bleeding was consistent with that reported on and off since the birth of her second child. Her previous bleeding was thought to be due to haemorrhoids, and the more severe symptoms were of much more recent onset. He stated that Mrs B mentioned a possible effect on her bowels from the long-term antibiotics for hidradenitis.

[21] Per rectum (from the rectum — the final section of the large intestine, terminating at the anus).
[22] For a complete blood count (CBC), iron studies, and C-reactive protein (CRP) (an indicator of inflammation).

34. Dr A said that he examined Mrs B's abdomen, which was normal. He did not perform a digital rectal examination, as Mrs B was upset. He considered new onset inflammatory bowel disease (IBD)[23] or irritable bowel syndrome (IBS)[24] as a possible diagnosis, with cancer less likely owing to her young age. The plan was for Mrs B to return for a more comprehensive examination, including the rectal examination, after she had had some blood and stool tests. Dr A told HDC: "I asked her to complete these tests and then to return for a follow up review in the near future at which time I would organise a referral if her symptoms had not resolved."

35. Mrs B did not have the stool test done, and did not return for review (for reasons unknown). She was seen on a further six occasions at the medical centre for unrelated matters,[25] and there was no report or mention of any bowel symptoms during these consultations until January 2018. Results of the blood tests undertaken by the dermatologist in June were unremarkable.

36. Dr A commented that at the time, he considered that Mrs B's symptoms were consistent with new onset inflammatory bowel disease, and there was a lack of progressive change in bowel habit or rectal bleeding since her October 2015 appointment, and she was not a high risk for malignancy because of her young age. He stated: "[The significance of the outlet bleeding was] confounded by the fact that [Mrs B] reported this pattern had been occurring on and off since childbirth in 2013 and I believed she had haemorrhoids." Dr A said that there was a two- to six-week duration of significant bowel change, and he "trusted [Mrs B] would return for review if it was persisting".

37. Dr A told HDC:

> "[W]ith the benefit of hindsight I accept that different decisions regarding [Mrs B's] treatment and management could have been made especially in light of the change in bowel habit and rectal bleeding for which she consulted me on 7 June 2017."

Tracking results and follow-up

38. The medical centre's Management of Clinical Investigations Policy states:

> "[T]he providers will use the taskbar messaging system as a back up.
> The task bar reminds the provider who ordered the test if the result has not returned.
> The patient should then be contacted by text message, phone or mail — there is a letter for this purpose in the 'Out' box called 'Test X' and a text message called 'Txtdo'."

39. Dr A said that blood tests, laboratory investigations, or radiology referrals have a task reminder set automatically. He stated that the dermatologist had ordered bloods for Mrs B on 6 June 2017, and said:

[23] Chronic inflammation of the digestive tract, including ulcerative colitis and Crohn's disease.
[24] A common disorder that affects the large intestine causing pain in the stomach, with wind, diarrhoea, and constipation.
[25] Not all with Dr A.

> "[When I viewed these results on or after 7 June 2017,] [t]his may have inadvertently led to the task reminder associated with my laboratory request being completed/ticked by myself when these investigations were reviewed and filed in the patient inbox in the belief they were the laboratory tests ordered at the health centre by myself."

40. Regarding the blood and stool tests that he asked Mrs B to complete on 7 June 2017, Dr A acknowledged that he "should have ensured [Mrs B] completed the investigations and returned for a complete examination".

41. On 18 July 2017, a respiratory physician ordered blood tests, and the results, copied to Dr A, showed a further drop in haemoglobin to borderline levels, consistent with iron deficiency. The results were annotated with Dr A's initials, with no further comment.

Consultations from August to October 2017

42. Mrs B returned for consultations with various doctors at the medical centre in August, September, and October 2017. The consultations were focused on her back pain and back surgery that was performed in September 2017.

Consultation with another GP 25 January 2018

43. On 25 January 2018, Mrs B was seen by Dr F at the medical centre, as Dr A was unavailable. Mrs B presented with constant tailbone pain, and had become severely constipated ten days earlier. Dr F recorded that Mrs B had had loose stools for many years, often had bright red or darker red blood in the toilet bowl, and had a family history of bowel cancer in her paternal aunt and grandmother aged in their forties.

44. Dr F performed a rectal examination and found a rectal mass. She then referred Mrs B to General Surgery at the DHB for clinical assessment for a high suspicion of cancer. Mrs B was diagnosed with advanced stage 4 bowel cancer. She underwent neoadjuvant chemoradiotherapy [26] followed by surgery and palliative chemotherapy/radiotherapy. Sadly, Mrs B passed away in 2019.

Further information

45. Mrs B told the Advocacy Service[27] that she wanted Dr A to be held accountable, and she felt a duty to help prevent something similar happening to anyone else.

46. The medical centre expressed its sincere condolences to Mrs B's family for their loss.

47. Dr A said that he "will be mindful of this case for the remainder of [his] medical career and Life". He told HDC:

> "I try and provide healthcare that covers the full gamut of physical, mental and social wellbeing and I deeply regret that I was unable to do this for [Mrs B] in June 2017."

[26] Initial treatment for cancer provided before the main treatment.
[27] The Nationwide Health and Disability Advocacy Service.

Responses to provisional opinion

Mr B

48. Mr B was given an opportunity to respond to the "Information gathered" section of the provisional opinion. Mr B commented that if his wife had not been turned down for a colonoscopy, perhaps something could have been found earlier and this could have resulted in a quicker diagnosis.

Dr A

49. Dr A was given an opportunity to respond to the provisional opinion. He accepted the proposed recommendations and follow-up actions.

50. Dr A acknowledged that different decisions regarding Mrs B's treatment and management could have been made, and added that this is very much said with the benefit of hindsight. He reiterated the complexity of the clinical picture with a number of active, complex medical conditions, and Mrs B's medical history, which he said influenced his management decisions. Dr A told HDC that he has taken this matter seriously and taken on board the deficiencies identified in his care, and has taken steps to improve his practice.

Medical centre

51. The medical centre was given an opportunity to respond to the provisional opinion and had no further comment to make.

Opinion: Introduction

52. This report highlights the need to ensure that tests are followed up, and follow-up appointments made, to support timely diagnosis. It also emphasises the importance of using critical thinking to reassess diagnoses when symptoms change. In my opinion, a number of oversights in Dr A's care contributed to a delay in Mrs B's diagnosis of bowel cancer, thus delaying her treatment. These are set out below.

53. I note that Mrs B had a number of active, complex medical conditions, and there were multiple secondary-care providers involved with various aspects of her medical conditions. I have not identified any concerns with the care provided by the secondary-care providers. I do acknowledge that the complexity and chronicity of Mrs B's medical conditions was a difficult background upon which to provide care and diagnosis, and I have taken this into consideration throughout the report.

Opinion: Dr A — breach

Follow-up of blood test results — March 2016

54. In late 2015, Mrs B had rectal bleeding and weight loss, and was iron deficient. Both a rheumatologist and a haematologist at the DHB recommended to Dr A that Mrs B be reassessed for iron deficiency and a referral made to gastroenterology for upper and lower GI endoscopy unless her iron deficiency and weight loss could be explained.

55. On 15 March 2016, Dr A ordered blood tests for Mrs B and re-prescribed iron supplementation. The results showed a drop in haemoglobin from previous results, and although her ferritin (iron) was low, this had not changed from her previous results. Dr A told HDC that he did not follow up on the blood test result with a referral to gastroenterology as there had been no change in Mrs B's iron level, she had not reported any further rectal bleeding, and there were ongoing clinical causes for the low iron storage (heavy menstrual bleeding and hidradenitis suppurativa).

56. However, my in-house advisor, GP Dr David Maplesden, advised that the results from 16 March 2016 indicated that no change in Mrs B's iron levels signalled a lack of response to the course of iron supplementation, and should have warranted follow-up. Consequently, a referral to gastroenterology requesting an endoscopy was indicated based on the haematologist's and rheumatologist's recommendations. I accept Dr Maplesden's advice that Dr A's failure to follow up the March 2016 test results with a referral to gastroenterology was a mild departure from accepted practice.

Documentation and further blood tests — 27 April 2017

57. On 27 April 2017, Mrs B visited Dr A regarding her back pain, and at the end of the consultation she mentioned her irregular bowel habit.

58. Dr Maplesden advised that best practice would have been to examine Mrs B's abdomen, refer her for blood tests,[28] and determine a suitable management plan based on the results. In addition, Dr Maplesden advised that Dr A should have done a rectal examination if Mrs B had complained of rectal bleeding, or documented the absence of rectal bleeding if she gave that history.

59. No physical examination was performed, and the absence of rectal bleeding is not documented. Dr A told HDC that Mrs B had experienced intermittent abdominal pains over a number of years with alternating constipation and diarrhoea, and she did not mention any rectal bleeding at this consultation. Dr A told HDC that he would have asked Mrs B if she had had any rectal bleeding, as his provisional diagnosis and management plan would have been quite different if she had had this symptom.

60. Dr Maplesden advised that he would expect patients in Mrs B's circumstances to be questioned directly regarding the presence of rectal bleeding. In the absence of evidence to the contrary, I accept that Dr A asked her if she had rectal bleeding, and that she did not

[28] Complete blood count and iron studies.

mention that she had. I therefore accept that this aspect of Dr A's care was appropriate. However, I am concerned that Dr A did not examine Mrs B's abdomen and did not document the absence of rectal bleeding.

61. Dr A's management plan was for treatment for inflammatory bowel disease (IBS) and "blood and stool tests and possibly a Gastroenterology review if no satisfactory response".

62. I accept Dr Maplesden's advice that it was reasonable to diagnose IBS and commence a trial of treatment if there was no history of rectal bleeding. However, I note that he was mildly critical that the blood tests were not repeated at this consultation to exclude progressive iron deficiency, considering that the last blood tests had shown persistently low ferritin and Mrs B was now presenting with concern about lower GI symptoms. I accept Dr Maplesden's advice and am critical that the tests were not repeated.

Tracking of management plan — 7 June 2017

63. On 7 June 2017, Mrs B visited Dr A in a distressed state, and options for managing her anxiety were discussed. She also reported bowel symptoms.

64. Dr A did not enquire about a family history of bowel cancer. Dr Maplesden advised that best practice would have been to determine any family history of colorectal cancer, and I accept his advice that the failure to do so is a mild departure from the accepted standard of care.

65. There is no record of a physical examination. Dr A stated that he examined Mrs B's abdomen (which was normal) but deferred a rectal examination because of her psychological distress (which was of a sensitive nature), until after she had had her blood and stool tests. Dr Maplesden advised that deferring a rectal examination was reasonable under the circumstances described.

66. Dr A said that he considered new onset IBS or IBD as a possible diagnosis, with cancer less likely owing to her young age. He commented that the previous bleeding was thought to be due to haemorrhoids, and there was not a progressive change in bowel or bleeding since 2015, with the significant bowel change occurring over the last 2–6 weeks. Dr Maplesden advised that considering and investigating a diagnosis of IBS or IBD was appropriate.

67. Dr A's management plan was for Mrs B to return for a more comprehensive examination, including a rectal examination, after she had had her blood and stool tests, and for him to organise a referral for her if her symptoms had not resolved.

68. Dr Maplesden considered that the management plan was reasonable. However, in Dr Maplesden's opinion, "there were features of [Mrs B's] presentation at this point that were not consistent with IBS — rectal blood loss and abdominal pain waking her at night". Dr Maplesden advised:

> "I believe it was imperative that [Dr A] arranged to track [Mrs B's] blood and faeces results to ensure they were undertaken in a timely manner, and physical assessment was also completed in a timely manner once [Mrs B] felt more comfortable with this."

69. Dr A told HDC: "I trusted [Mrs B] would return for review if it was persisting." However, Mrs B did not have a stool test done, and did not return for review. She was seen on a further six occasions at the medical centre (not all with Dr A) for unrelated matters, and there was no report or mention of any bowel symptoms during these consultations until January 2018.

70. Dr A has acknowledged that he should have ensured that Mrs B completed the investigations and returned for a complete examination. He said that he reviewed the blood tests ordered by the dermatologist in June 2017 (which were unremarkable), and he thinks that he ticked the task reminder for the tests he had ordered as having been completed, so there was no alert for the outstanding tests that had yet to be performed. However, there is nothing to suggest that Mrs B was contacted regarding those results and to schedule the intended review. Dr Maplesden advised:

> "I think this was a weakness in [Dr A's] tracking process at the time and the changes in clinical practice he has outlined in his responses should ensure more robust tracking in the future."

71. Dr Maplesden advised that "the clinical picture was sufficiently suspicious for significant colorectal pathology, whether IBD (most likely) or [colorectal] C[ancer] (less likely given [Mrs B's] age), to warrant tracking of the management plan". Dr Maplesden considered that the failure by Dr A to ensure that the plan was completed in a timely manner was a moderate departure from accepted practice.

72. I accept Dr Maplesden's advice and am concerned that Dr A did not follow up the blood and stool sample and did not track Mrs B's management plan. Dr A should have used the taskbar messaging system to remind him that the test he had ordered had not been returned. Mrs B should then have been contacted by text message, phone, or mail as per the medical centre's Management of Clinical Investigations Policy (Appendix B).

July 2017

73. On 18 July 2017, a respiratory physician ordered blood tests, and the results, copied to Dr A, showed a further drop in haemoglobin to borderline levels, consistent with iron deficiency. The results were annotated with Dr A's initials with no further comment.

74. I am critical that Dr A did not follow up Mrs B when the results received on 18 July 2017 suggested progressive iron deficiency. This was another missed opportunity to follow up by referring her to gastroenterology. Mrs B was not referred to gastroenterology until her consultation with another GP at the medical centre on 25 January 2018. She was then diagnosed with advanced stage 4 bowel cancer and, sadly, passed away in 2019.

Conclusion

75. Dr A had a responsibility to provide services to Mrs B with reasonable care and skill and, in my opinion, he did not discharge that responsibility. There were missed opportunities to refer Mrs B for a lower GI endoscopy, and this led to a delay in Mrs B receiving a diagnosis and treatment for bowel cancer. In March 2016, Dr A should have recognised unexplained iron deficiency and referred Mrs B for endoscopy. In April 2017, Dr A should have examined

Mrs B's abdomen and ordered repeat blood tests to exclude progressive iron deficiency. In June 2017, Dr A should have contacted Mrs B to encourage her to return for a rectal examination and complete blood and stool tests. There was another lost opportunity for follow-up in July 2017 on receipt of blood tests suggesting progressive iron deficiency. While each of these failures may appear mild when viewed individually, cumulatively they present a pattern of poor care. Accordingly, I find that Dr A breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[29]

Opinion: Medical centre — no breach

76. Dr A was working at the medical centre. As stated above, I have found Dr A to be in breach of the Code for failing to provide an adequate standard of care to Mrs B.

77. I consider that Dr A's failures were individual errors. I note that the medical centre had in place a "Management of Clinical Investigations Policy", which outlined the process for ensuring that "patients have clinical investigations and referrals attended to in a timely manner". Part of this process stated that "providers will use the taskbar messaging system as a back up". Unfortunately, when tracking the management plan from 7 June 2017, Dr A believes that he checked the task reminder for blood and stool tests as completed when he reviewed the blood test results from the dermatologist. This meant that there was no alert for the outstanding blood and stool tests that had yet to be performed, and the intended review was not scheduled.

78. I am satisfied that the policy was appropriate, and commend the medical centre for changes it has made, as outlined in the "Changes made since events" section below, including the ability to set a reminder for every test ordered, and the appointment of a Practice Administrator to monitor all incoming results/correspondence and flag to the appropriate person any results over four weeks old.

79. I have considered whether other doctors who saw Mrs B between August and October 2017 should have noticed a lack of follow-up on Dr A's management plan. I note that these consultations focused on her back pain and back surgery that was performed in September 2017. I also note that there is no mention of bowel issues being raised by Mrs B, and no follow-up alerts on the system, and I am therefore not critical of the other doctors' care in these circumstances. However, I emphasise what this Office has stated previously[30] — that medical centres need robust systems in place to ensure the facilitation of communication and cooperation between each doctor — and this is even more vital when a patient is seeing multiple providers.

[29] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[30] HDC case 19HDC01558, available at https://www.hdc.org.nz.

80. I am satisfied that Dr A's failures do not relate to any systems or organisational issues at the medical centre. Accordingly, I do not find the medical centre in breach of the Code.

Opinion: Dr C — other comment

81. On 10 November 2015, Dr C reviewed Mrs B to investigate her iron deficiency. Dr C took a history (which included rectal bleeding, haemorrhoids, and weight loss) and performed an abdominal and rectal examination. She did not ask Mrs B whether she had a family history of GI cancer. Dr Maplesden advised that this was not a departure from common practice, "taking into account Mrs B's age, the outlet-type bleeding she described and the impression given in [Dr E's] letter that the weight loss had been previously investigated".

82. I note that Dr C attributed Mrs B's weight loss of 25kg over 12 to 18 months to her steroid reduction, multiple family bereavements, and ongoing infections with hidradenitis. I also note Dr Maplesden's advice that that approach was reasonable, and that weight measurements from 2015 onwards do not show any concerning pattern of ongoing weight loss, and Mrs B's weight remained above the ideal range. In my view, Dr C's assessment of Mrs B's weight loss was reasonable.

83. I also consider, in reliance on Dr Maplesden's advice, that Dr C's management plan was reasonable, but that the safety-netting advice and abdominal examination could have been documented more clearly. As Dr Maplesden advised:

> "[I]t is common and accepted practice to document the findings of an abdominal examination even when normal when such an examination is performed in patients with GI symptoms and I am mildly critical this documentation was omitted."

84. Overall, Dr C's care of Mrs B on 10 November was reasonable. I note that Dr C has acknowledged that her documentation could have been more extensive, and I encourage GPs to be mindful of keeping adequate medical records to support patient safety and continuity of care.

Changes made since events

85. The medical centre has:

- Discussed Mrs B's care at its Clinical Governance Group meeting, encouraging continuity of care for patients through reception bookings and messages on the patient information screen in the reception area. All doctors working at the medical centre now work a minimum of 0.6 FTE[31] with the aim of improving continuity.
- Trialled all GPs being present for regular peer review meetings to improve handover and discuss cases.
- Encouraged GPs to ask patients to return for a follow-up appointment if they are not able to complete a full assessment of the patient in one appointment.
- Signed up for the Healthcare homes model of practice and also a Client Led Integrated Care programme, to help practices manage workload and work more efficiently and offer additional supports to those people with higher health needs and multiple comorbidities.
- Reviewed the Management of Clinical Investigations policy.
- Appointed "the Practice Administrator to be responsible for monitoring all incoming results/correspondence to the provider inbox on a daily basis. Any results over 4 weeks old will be flagged to the requesting clinician or buddy to action as appropriate" (the Management of Clinical Investigations policy, updated in 2019).
- Gained the ability to set a reminder for every test ordered since changing to an e-ordering system.

86. Dr A has:

- Attended seminars/courses/online learning focusing on gastroenterology, colorectal disease, familial cancers, and bowel screening, including at the NZMA conference.
- Structured his next practice development plan around these topics, and will use his peer group and immediate colleagues to ensure that this learning is relevant to his practice.
- Reviewed the Royal Australasian College of Physicians presentation on cognitive factors and diagnostic delay, and included the clinical reasoning in his current practice development plan.
- Raised at team meetings and peer group sessions that not all GPs at the medical centre are familiar with using proctoscopes.
- Discussed this case at length with his peer group and practice colleagues.
- Ensured that a task is recorded for all investigations, and the patient contacted if the relevant investigations are not back in a reasonable time frame. Alerts are set so that other GPs at the medical centre are aware of an issue when they first open the patient's record.

[31] Full-time equivalent.

- Changed his practice with any patients who require a definite follow-up appointment, making the appointment in the patient's presence or asking the reception staff to make an appointment on the encounter slip that day. If a patient changes or cancels their appointments, he sets a task reminder to ensure that they have been back for timely review.
- Changed his appointment books to allow dedicated administration time at the end of each clinic session to review the session in close time proximity to patient consultations to address any follow-up recall and safety-netting issues.

Recommendations

87. In the provisional opinion, I recommended that Dr A provide a written apology to Mr B and his family for the failings identified in the report. In response, Dr A provided an apology to HDC, which has been forwarded to Mr B.

88. I recommend that Dr A review the RACP presentation[32] on cognitive factors in diagnosis, and reflect on the likely cognitive processes and decision-making that contributed to a diagnostic delay for Mrs B. Dr A is to report back to HDC on these reflections and learnings within three months of the date of this report.

89. I note that the Medical Council of New Zealand received a notification of risk of harm from the Accident Compensation Corporation (ACC) on 3 December 2018 and requested that Dr A undergo a preliminary inquiry into his current practice. The Medical Council was satisfied with the outcome, and took no further action. Therefore, I am not recommending that the Medical Council consider a further competence review of Dr A.

Follow-up actions

90. 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 A's name in covering correspondence.

91. 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.

[32] https://www.racp.edu.au/docs/default-source/Events/congress-2017-presentations/racp-17-tue-scott-heslop.pdf?sfvrsn=2 Accessed 9 July 2020.

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 [Mr B] per … about the care provided to his late wife, [Mrs B] by [Dr A] 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 documentation on file: complaint from [Mr B]; response from [Dr A] (GP); response from Dr C (GP); GP notes [the medical centre]; response from [the DHB] and clinical notes [the public hospital] (DH); response from rheumatologist Dr E).

2. The complaint related to a delayed diagnosis of colorectal cancer (CRC). The complainant states [Mrs B] presented to [Dr A] on many occasions between 2015 and 2018 with bowel symptoms (constipation, diarrhoea, rectal bleeding) and was provided with symptomatic treatment and told she probably had irritable bowel syndrome (IBS). She eventually saw a different GP in late January 2018 and was referred for specialist review. This resulted in a diagnosis of advanced CRC and [Mrs B] sadly succumbed to her disease [in 2019] at the age of … years.

3. Response from [Dr A] includes the following points:

(i) [Dr A] was [Mrs B's] registered GP from 2012. He was on [extended leave during part of] 2015 and [Dr C] cared for his patients over this period.

(ii) [Mrs B]'s medical history included severe asthma (past history steroid dependency and life-threatening symptoms); hidradenitis suppurativa; anxiety and depression; history of venous thromboembolism (DVT); essential thrombocytosis; chronic mechanical back pain. From 2014 she was under the care of DHB dermatology service (outpatients) and had been treated with rotating course of antibiotics and regular review of her asthma by the DHB respiratory service.

(iii) [Dr A] states: *[Mrs B's] reported bowel pattern was not consistent and went between constipation and diarrhoea over many years prior to the onset of weight loss and iron deficiency. The records show a number of occasions when blood in her stool was noted in a pattern consistent with haemorrhoids. This was reported as far back as 2007 (when she was treated for perianal abscesses by the General Surgery Department), March 2013 when she was treated for a thrombosed external haemorrhoid by the Emergency Department at [the DHB] and again in 2015 when she saw [Dr C] with a history of fresh rectal blood loss consistent with haemorrhoids. Indeed, the Emergency Department notes from 2013 record her as stating that passing blood with stool was normal for her.*

(iv) [Dr A] states: … *I feel that [Mrs B's] long and complex medical history (both from a physical and mental health perspectives) as well as the involvement of multiple GPs at [the medical centre] and specialists complicated my assessment of the fresh bleeding reported on 7 June 2017 … at the time I considered her symptoms were consistent with*

new onset inflammatory bowel disease. My index for suspicion of malignancy was low because of her young age, an episodic pattern of rectal bleeding believed to be due to haemorrhoids going back over several years, a lack of progressive change in bowel habit or rectal bleeding following her October 2015 appointment and a 2–6 week duration of significant bowel change. I trusted she would return for review if it was persisting … However, in the 5 subsequent consultations with myself and other GPs at [the medical centre], 3 specialist outpatient appointments at [the public hospital] and an inpatient stay for lumbar disc surgery, [Mrs B] made no further mention of bowel symptoms, until the consultation in January 2018 when the diagnosis was finally made. Unfortunately, [Mrs B] did not complete the stool sample I requested on 7 June 2017. Receiving this result, no doubt would have prompted me to enquire again regarding bowel symptoms, and action appropriate specialist referral.

(v) With respect to the issue of [Mrs B's] weight loss from 2015, [Dr A] noted: *prior to 2015, [Mrs B] had been steroid dependent for control of her severe asthma for several years and was further weaned off prednisone, at that point 3mg daily on a 1 mg per month reduction basis following her Respiratory outpatient appointment on 29 April 2015. Prior to that she had been on doses as high as 6mg through latter part of her pregnancy and decreasing to 10mg orally after her delivery and further stabilisation of her asthma. I attributed the weight loss to the prednisone reduction and chronic infection relating to her hidradenitis. This was the view of the Rheumatologist she consulted with on 13 October 2015 and Haematologist in November 2015. This was in part because there was no report of change in bowel habits or report of PR bleeding at the time. [A] Respiratory Physician wrote in a previous letter on 15 October 2014 when [Mrs B] had reduced to a maintenance dose of 10mg Prednisone 'It was really good to see that [Mrs B] has dropped her weight to 75kg by a combination of healthy eating choices and a bit more physical activity.'*

4. Response from [Dr C] includes the following points:

(i) [Dr C] saw [Mrs B] on three occasions in 2015 on behalf of [Dr A] who was overseas. She elaborates on the consultation dated 10 November 2015. A letter had been received from [Dr E] on 21 October 2015 recommending [Mrs B] be reassessed with a view to referral to gastroenterology unless good explanations for her weight loss and iron deficiency could be identified. The letter included the comment: *She tells me she has lost 35 kilograms in weight over the last year. This has been looked into and attributed to Prednisone reduction and perhaps her chronic infection related to her hidradenitis. There has been no change in bowel habit or fevers or night sweats.*

(ii) [Mrs B] was sent an invitation to attend [the medical centre] and was seen by [Dr C] on 10 November 2015. History was obtained of longstanding rectal bleeding, irregular bowel pattern, some upper GI symptoms responding to omeprazole, and irregular periods on Noriday. Unintended weight loss of 25kg over the previous 12–18 months was documented (current weight 71kg). Rectal examination showed some internal haemorrhoids. Further blood tests were ordered and intention to consider surgical referral for haemorrhoids is documented.

(iii) [Dr C] states: *While my safety-netting advice should have been better recorded in the notes, and I apologise for this, I believe I explained to [Mrs B] that she would need to come back if her rectal bleeding persisted. Given her history, I discussed with her that if things did not settle down, I would need to consider a referral for further investigation (including possible surgery for her haemorrhoids, which is recorded in my note). My plan also included following up on the further blood tests I had ordered. Indeed, that test showed her iron stores had improved compared to when the previous test a few weeks earlier; and then I ordered a further blood test for one month's time to see what her iron levels were doing. I knew this further test would occur when she was back in the care of her usual GP, but that it would prompt further consideration of any evolving symptoms.*

(iv) [Mrs B's] November 2015 blood tests showed an improvement from those undertaken on 21 October 2015. A message was left with nurses to contact [Mrs B] with the comment: *She should still come in to be reviewed regarding the iron deficiency, but I think we should wait until one month after her operation* (for excision of hidradenitis suppurativa lesions) *and retest her iron then, as it may have been because of her ongoing infections.* [Mrs B] subsequently saw [Dr A] again for her ongoing care.

5. Response from [Dr E] includes the following points:

(i) [Dr E] first saw [Mrs B] on 12 October 2015 following a referral by [the respiratory physician] because of chronic low back and body pain. History of recent weight loss was noted (35kg over previous year coinciding with prednisone reduction) together with essential thrombocythaemia (investigated by haematologists) and recent blood tests showing iron deficiency. [Dr E] states: *I recommended to her GP, [Dr A], (by letter dated 21 October 2015), that she be fully reassessed for iron deficiency with the recommendation that a referral be made to the Gastroenterologists for upper and lower GI endoscopy unless her iron deficiency and weight loss could be explained.*

(ii) At review on 29 February 2016, [Dr E] noted lumbar X-ray findings suggesting spondylosis and spinal MRI and nuclear medicine bone scan were requested. [Mrs B] had been seen by a haematologist and following bone marrow biopsy she had been commenced on iron supplementation with a plan to refer for endoscopy if there was no response (Haematology Clinic letter 10 December 2015).

(iii) At next review on 27 June 2016 MRI findings were discussed (small disc bulge and longstanding ovarian cyst — latter followed up with tumour markers and ultrasound and confirmed benign). [Mrs B] was complaining of some lower limb neurological symptoms and was referred for nerve conduction studies. [Dr E] states she would have questioned [Mrs B] regarding bowel symptoms at this time (to exclude cauda equina syndrome) and no issue with bowels was documented. Management was to include use of NSAIDs[1] and [Dr E] requested upper GI endoscopy through the DHB gastroenterology service because of this factor, and noting [Mrs B's] history of iron deficiency (intention to exclude any significant upper GI pathology that might preclude use of NSAIDs). The

[1] Nonsteroidal anti-inflammatory drugs.

request was declined via a letter from gastroenterologist [Dr D] dated 21 July 2016 which noted the most common cause of isolated low ferritin in [Mrs B's] age group was menstruation (whether or not heavy) and this finding alone was not an indication for endoscopy. [Dr E] notes also that [a haematologist] had referred [Mrs B] for gastroscopy prior to July 2016 but this request had been declined.

(iv) Nerve conduction studies were consistent with a degree of S1 radiculopathy and an injury to the left sural nerve (secondary to previous surgery). [Dr E] notified [Dr A] of the results and recommended conservative management but spinal surgeon referral if symptoms persisted or worsened. She did not see [Mrs B] again after June 2016. I note [Dr A] referred [Mrs B] for spinal surgery with L5-S1 micro-discectomy undertaken on 15 September 2017.

6. The DHB response includes the following points:

(i) [The haematologist] is unfortunately deceased. [Another haematologist] saw [Mrs B] in October 2017 and states: *she was still iron deficient, but she didn't mention any bowel changes to me.*

(ii) Gastroenterologist Dr D makes the following comments:

- *[Mrs B] had laboratory evidence of isolated hypoferritinaemia without anaemia in April 2014. On review, previous results appear to relate to pregnancy-related changes. This biochemical finding was first noted in correspondence from Dr … (Haematology) in November 2015 who commented that he suspected the low ferritin, in isolation, could be explained by dietary insufficiency, compounded by steroid and bisphosphonate therapy. It was also noted that the patient was still menstruating and didn't have coeliac disease on serological testing.*

- *A referral for gastroscopy was received from [the haematologist] in June 2016 'to exclude malabsorption'. At this point there was no evidence of anaemia, nor were any localising gastrointestinal symptoms reported, though it is noted that the patient was also taking aspirin (in addition to steroids and bisphosphonate therapy). In the absence of anaemia, localising gastrointestinal symptoms, or any other symptoms or evidence to suggest a malabsorptive problem, the referral for gastroscopy was not accepted in line with DHB criteria for gastroscopy. These criteria apply to all received referrals for consistency and transparency and are clinically based.*

- *A second referral for gastroscopy was received from [Dr E] in July 2016. The request was for endoscopic evaluation to determine the safety of continuing naproxen, or similar drugs. There is no evidence to support routine gastroscopy in individuals requiring anti-inflammatories in whom no new symptoms or complications have occurred. As the low ferritin level preceded the use of naproxen, and the other clinical information provided was no different to the referral received one month prior, the triage process outcome was the same.*

(iii) Dr D makes the observation *that [Mrs B's] subsequent diagnosis of rectal cancer, after assessment of symptoms of rectal bleeding and change in bowel habit, would not have been impacted by the outcome of these referrals for gastroscopy.*

7. Summary of references to bowel symptoms in clinical documentation (excluding GP notes — see s 10)

- ED note dated 10 March 2013 following review for perianal abscess: *bowels working normally — small amount of blood in stool, says this is longstanding.*

- Rheumatology letter dated 12 October 2015 (first assessment): *She has no bladder or bowel dysfunction … She tells me she has lost 35 kilograms in weight over the last year. This has been looked into and attributed to Prednisone reduction and perhaps her chronic infection related to her hidradenitis. There has been no change in bowel habit or fevers or night sweats.*

- Plastic surgical admission note dated 21 October 2015 (review of systems): *Abdominal: BO regularly, no change in habits.* No reference to unexplained weight loss in systems review.

- Haematology OP notes (handwritten) dated 4 November 2015: *bowels fluctuate but normal for her … lost ~35kg 12–18/15 unintentionally … no abdominal pain … no blood in urine …* [no reference to PR bleeding symptom]. These factors reiterated in clinic letter dated 10 November 2015.

- Neurosurgical OP letter dated 13 January 2017: *she has no symptoms affecting her right leg or sphincter functions.*

- Neurosurgical pre-admission note dated 31 August 2017 (review of systems): *GI: Ongoing IBS but stable.*

- Medical oncologist letter dated 1 March 2018 (following [Mrs B's] CRC diagnosis): *She recalled PR*[2] *bleeding for at last 8 years. She did have haemorrhoids with her youngest child who is about 4 now but can't recall ever having an examination and had been advised her symptoms were related to irritable bowel syndrome. Her bowel habit alternated between constipation and diarrhoea …*

8. Summary of weight recordings

[Dr A] reports records of [Mrs B] weighing 62 kg on 1 September 2006 and 62.0kg on 3 September 2007. Healthy weight range for [Mrs B's] height is 51–65kg. It appears she was within that range in 2006 and 2007 and then must have gained a very considerable amount of weight some time over the next eight years, possible coinciding with long-term steroid use which was very high dose during her pregnancy. I do not have a record

[2] Per rectum, bleeding from the rectum (the final section of the large intestine, terminating at the anus).

of her peak weight, but she reported to [Dr E] and [the haematologist] in October and November 2015 that she had lost 35kg in the preceding 12–18 months. Weight measurements from 2015 onwards appear below (taken from hospital records) and do not show any concerning pattern of ongoing weight loss and [Mrs B's] weight remained above the ideal range. Given this situation, I think it was probably reasonable to attribute [Mrs B's] presumed excessive weight gain then loss between 2013 and 2015 to her steroid use (gradually weaned and stopped by early 2015) rather than being related to any sinister pathology. However, this was more evident in hindsight (from 2015 onwards when her weight stabilised then increased).

Date	Weight (kg)
10/03/2015	70
29/04/2015	69.3
26/08/2015	69.6
4/11/2015	72.4
25/05/2016	77
17/08/2016	80.3
30/11/2016	81.6
20/06/2017	87
5/07/2017	89.6
1/03/2018	82.5
13/06/2018	79

9. Summary of references to iron deficiency in clinical documentation

- Rheumatology letter dated 21 October 2015: Note regarding diagnosis of likely essential thrombocythaemia and impending haematology review. *Finally, I also note that she is iron deficient with a ferritin of 16. She gave me a history of 35-kilogram weight loss and told me it had been fully assessed. In view of her weight loss and this new iron deficiency I recommend that she is fully assessed with a view to a referral to the Gastroenterologists for upper and lower GI endoscopy unless there are very good explanations for both her iron deficiency and weight loss. It may also be prudent to check her for coeliac disease and I recommend some coeliac serology. I am seeing [Mrs B] again in December and can follow up on some of these results but I thought her iron deficiency in particular needs addressing prior to then.*

- Haematology letter dated 16 November 2015 (first assessment a week earlier — see section 7): *[Mrs B's] iron studies show she is iron deficiency … her celiac screen has come back negative. I suspect [Mrs B's] iron deficiency is dietary, though it may possibly be related to the prednisone and etidronate which can cause oesophagitis/gastritis. I suggest putting her on iron supplementation and should she not attain an adequate response then referral her to the gastroenterologists … she did not feel her periods are heavy …*

- Respiratory letter dated 25 November 2015: *She is off prednisone completely now. I note there were no iron stores on the marrow visible and it would be, I think, reasonable to commence oral iron in the first instance. I will leave further assessment of the iron deficiency to [Dr A] now he is back from leave.*

- Haematology letter dated 9 December 2015 (following bone marrow biopsy result): *Her bone marrow aspirate was consistent with essential thrombocytopenia with no evidence of myelofibrosis. It did confirm she has no iron stores. She has since started iron supplementation. I would checking her iron studies again in about 2–3 months and if she has not had adequate response then referral to gastroenterology. She feels her red meat intake is adequate and her periods are not heavy. Usually we will put patients of her age on aspirin but given her history of severe asthma as well as a possibility of GI bleeding I have not done so.* (This is reproduced as written — unclear if [the haematologist] intended to follow-up the results or if was asking [Dr A] to do this (but see next section) and I have assumed [the haematologist] is referring to possible occult upper GI bleeding as there is no reference to him obtaining a history of [Mrs B's] rectal bleeding history.)

- No reference to iron deficiency in haematology letter dated 10 June 2016 (although [the haematologist] apparently referred [Mrs B] for gastroscopy at this time) or rheumatology letter dated 2 March 2016.

- Letters from gastroenterologist [Dr D] to [the haematologist] (22 June 2016) and [Dr E] (19 July 2016) declining gastroscopy (see [Dr D's] comments in section 6(ii)). It is apparent there was no reference in the referral notes sent to the gastroscopy service that [Mrs B] had a history of rectal bleeding, altered bowel pattern or weight loss if those symptoms were recognised at the time (see previous sections).

- Letter from rheumatologist dated 27 June 2016: *I also not that [Mrs B] is iron deficient despite supplementation and that [the haematologist] referred her to gastroenterology for gastroscopy. I have re-referred her as I am concerned about continued NSAID use in the presence of unexplained iron deficiency.*

- Letter from haematologist 14 September 2016: *I have asked her to double the dose of iron supplement as her ferritin remains low. Gastroenterology has not accepted her for GI investigations.*

- Letter from haematologist 16 October 2017: Depleted iron stores noted and *I suspect that we may have never given her a complete course of iron replacement … I have given her a prescription today for 325mg once daily of ferrograd and would you please follow it up with a repeat prescription to ensure that she gets adequate iron replacement.*

Haemoglobin and iron study parameters available from the GP notes are presented below. I suspect there are additional results on the DHB database but they have not been presented and it is unclear if they were available to the GP.

Date	Hb (115–155 g/L)	s Iron (10–30 umol/L)	Ferritin (20–200 ug/L)	Transferrin (2.0–3.5 g/L)	Transferrin Sat (16–50%)	Comment
12/08/2015	144					
21/10/2015	-	9	16	3.2	11	
10/11/2015	142	20	16	3.5	23	See s 11
15/03/2016	127		16			Annotated 'low' Iron tabs Rx
10/05/2016	138					
12/09/2016	130		18			Annotated 'low'
6/06/2017	120					MCHC borderline
18/07/2017	116					MCV & MCHC ↓
16/10/17	110					Per Haem letter to GP
25/01/2018	118	5	9	3.2	6	MCV & MCHC ↓

10. GP notes (available from 1 January 2015) and actions are reviewed from this point. There is no reference to [Mrs B's] presenting symptoms related to her bowel pattern or rectal bleeding in 2015 until the consultation of 10 November 2015 proactively arranged by [Dr C] after receiving recommendations from the rheumatologist regarding investigation of [Mrs B's] weight loss and iron deficiency. [Mrs B] was reviewed for unrelated medical and psychological issues over this period and was also regularly reviewed by the DHB respiratory service and had an inpatient admission for excision of hidradenitis suppurative lesions. I note that between the start of 2015 and the time of her diagnosis of CRC, [Mrs B] had at least 25 DHB specialist contacts (respiratory, haematology, rheumatology, neurosurgery, dermatology, orthopedic).

11. The consultation with [Dr C] dated 10 November 2015 reads:

review re iron deficiency.

Possible causes: bleeding haemorrhoids most days of month, with dripping in toilet and often prolapsed haemorrhoid. currently ok.

bowels some mix between constipation and diarrhoea

periods irreg on noriday, takes it to control bad period pains, which it does but irreg bleeding. Can't take COC due to DVT. husband had vasectomy

takes omeprazole 40bd and if doesn't gets major reflux sx. no worse with ibuprofen Weight loss — 25 kg over last 12–18 months as per hospital scales. not trying. 9 family deaths in last yr. ongoing infections. just diagnosed with thrombocythaemia

Objective: Wt 71 kg

pr no external piles, swelling internally at 8 o'clock and 4 o'clock.

Imp numerous causes for weight loss and also for iron low.

P rept iron, and coeliac screen. consider referral to surgeons re piles. try microlut to see if better period control.

If needs iron tabs needs laxsol

Prescription was provided for [Mrs B's] usual medications and blood test form provided to repeat CBC, iron studies, ferritin and coeliac screen. Results showed improvement in iron study parameters although ferritin was unchanged (see s 9). [Mrs B] was contacted with her results and, per [Dr C], was advised: *She should still come in to be reviewed regarding the iron deficiency, but I think we should wait until one month after her operation* (for excision of hidradenitis suppurativa lesions which was undertaken 21 October 2015 and was complicated by post-op infection) *and retest her iron then as it may have been because of her ongoing infections.* Repeat blood test form was generated on 16 November 2015.

Comments:

(i) [Dr C] was not [Mrs B's] regular GP and had no prior knowledge of [Mrs B's] bowel history other than what was recorded in the historical notes (not available to me). The rheumatologist letter (s 9) gave a reasonably explicit recommendation for review as: *In view of her weight loss and this new iron deficiency I recommend that she is fully assessed with a view to a referral to the Gastroenterologists for upper and lower GI endoscopy unless there are very good explanations for both her iron deficiency and weight loss.* However, the rheumatologist had not obtained a history of rectal bleeding and the reason for this is unclear. [Dr C] obtained a history of longstanding persistent outlet-type bleeding on the background of history of haemorrhoids, including intermittent prolapsing of haemorrhoids. Irregular bowel pattern was documented although this is not noted as a change in pattern (and apparently was also longstanding). Very significant weight loss was noted (see s8). [Dr C] explored other potential causes for [Mrs B's] iron deficiency and noted presence of upper GI symptoms when not using omeprazole, and irregular periods on the mini-pill. I believe the history taken by [Dr C] was mostly adequate, but I am mildly critical there was no exploration of family history of GI cancer. [Mrs B] did not appear at particular risk of CRC by virtue of her age, but a relevant positive family history would alter the threshold for suspicion of the disease.

In hindsight, [Dr F] established in January 2018 that [Mrs B] had a family history of CRC with two second degree relatives on the same side of the family (paternal aunt and paternal grandmother) both diagnosed with CRC in their 40's. It is unclear whether the diagnoses were in association with multiple bowel polyps or other familial CRC syndrome which would have placed [Mrs B] at potentially high risk of CRC. Based on the available history, [Mrs B] would not have fitted any increased risk criteria per NZ guidelines[3].

(ii) [Dr C] has documented performing an anal inspection and digital rectal examination, the latter suggestive of internal haemorrhoids. There is no reference to presence of blood on the glove. Proctoscopy is often undertaken in the situation described and can be useful to determine the site of bleeding or extent of local pathology such as haemorrhoids but I note it does not constitute part of current local guidance for investigation of colorectal symptoms[4]. I would therefore regard the procedure as best practice rather than necessary practice. However, abdominal examination should have been performed to exclude an abdominal mass and I am mildly to moderately critical this examination was not undertaken and/or not documented.

(iii) [Dr C] was therefore presented with a young patient with significant weight loss, chronic outlet-type rectal bleeding which had previously been attributed to haemorrhoids, haemorrhoids palpable on DRE, some upper GIT symptoms controlled with omeprazole, and ferritin deficiency. There was no recent change in bowel pattern. [Mrs B] did not have anaemia at this point and red cell parameters were normal. She had longstanding chronic hidradenitis suppurativa, and was in the process of withdrawing from chronic prednisone use for asthma control. I agree that given the clinical picture, there were numerous possible causes for the weight loss and ferritin deficiency but I feel because of this, further investigation of the GI tract (upper and lower) was required, in particular because of the alarming weight loss and whether or not the rectal bleeding was perceived to be related to haemorrhoids. However, [Mrs B] did not fulfil the [DHB] criteria for direct access to colonoscopy/colonography and a general surgical or gastroenterology referral was required to facilitate further investigation (endoscopy). I do not believe it was appropriate at this stage to assume [Mrs B's] weight loss was due to steroid withdrawal and/or chronic infection without excluding GI pathology by way of appropriate referral, particularly given the presence of GI symptoms (albeit not new) and low ferritin. I acknowledge low ferritin is not uncommon in menstruating females, and the perceived risk of [Mrs B] having a GI malignancy was, quite reasonably, low given her age. I note [Dr C] recorded an intention for surgical referral if [Mrs B's] further blood tests did not show improvement in her iron parameters, and it was reasonable to await the result of the coeliac screen before making a referral. The fact there was some improvement in the iron parameters on repeat testing is a mitigating factor, but this did not, in my opinion, obviate the need to proceed with surgical referral to exclude [Mrs B's] GI symptoms as being related to her

[3] https://www.health.govt.nz/system/files/documents/publications/brochure-primary-care-colorectal-cancer.pdf Accessed 9 July 2020

[4] Community Health Pathways section on 'Colorectal Symptoms'. Accessed 9 July 2020

weight loss. Another mitigating factor is that [Dr C] advised repeat blood tests in a further month with the result to direct ongoing management under [Dr A] on his return. However, there was deficient documentation of any 'safety-netting' advice provided to [Mrs B] with respect to monitoring of GI symptoms or weight, and it is not apparent from the responses or notes there was any formal handover regarding the complex clinical issues to [Dr A] on his return. Taking all of these factors into account, I am mildly to moderately critical of [Dr C's] management of [Mrs B] in November 2015.

(iv) It is only with the benefit of hindsight that it appears [Mrs B's] weight loss in 2014–15 was unrelated to any underlying malignant process, but the stabilising of her weight then increase from 2016 onwards was reassuring with respect to weight loss being a 'red flag' symptom. [Dr C's] response indicates she has reflected appropriately on her management of [Mrs B] and I recommend she review the cited HealthPathway guidance on colorectal symptoms and a UK article on investigation and diagnosis of unexplained weight loss cited below[5].

12. On 25 November 2015 [Dr A] has annotated receipt of the haematologist letter (see s9, bullet point 2) as *rx iron for 3/12 then rv hb and ferritin, refer gastro then if not improve.* Prescriptions were generated for iron and Vitamin C. Recall letter and blood test form were sent to [Mrs B] on 11 February 2016 and results received 15 March 2016 with ferritin result annotated as 'low' but no further actions evident. Further iron was prescribed on 16 March 2016. On 28 April 2016 there was a consultation for headache during which [Dr A] noted: *can stop Microlut — periods quite irregular and heavy — monitor.* Blood tests were ordered on 9 May 2016 but this did not include ferritin. Recall letter and blood test form was sent on 7 July 2016 but evidently not completed by [Mrs B]. On 22 July 2016 a note regarding declining of gastroscopy was received (see s 6(ii) and s9). On 12 September 2016 [Dr A] acknowledged receipt of ferritin result as 'low' but there is no additional action documented. Iron tablets were prescribed on 28 September 2016. During 2016 there were additional consultations for unrelated medical and psychological issues but there was no reference in any consultation to complaint of rectal bleeding or other GI symptoms.

Comment: [Mrs B] had numerous specialist consultations through 2016 and relevant portions of the clinic reports have been reproduced in previous sections. Ongoing weight loss was no longer an issue and there is no record of [Mrs B] raising the issue of persisting GI symptoms (including PR bleeding) with any of her providers in 2016. Nevertheless, I am mildly critical [Dr A] did not follow-up the blood result of March 2016, which showed an inadequate response to oral iron replacement, with referral to gastroenterology as recommended by the haematologist in his preceding letters. I note subsequent referrals for gastroscopy made later in 2016 by [the haematologist] and [Dr E] were declined on the basis of the clinical information supplied. I cannot predict whether a referral by [Dr A] would have been similarly declined, but given his awareness

[5] Jey S. Unintended weight loss: what's the diagnosis? Guidelines in Practice. 2020. https://www.guidelinesinpractice.co.uk/gastrointestinal/unintended-weight-loss-whats-the-diagnosis/455063.article Accessed 9 July 2020

of [Mrs B's] PR bleeding symptom (of which neither [the haematologist] nor [Dr E] were apparently aware) I would expect this symptom to have been included in the referral which may or may not have influenced the outcome. It does appear that on the basis of the information supplied to [Dr D], he was correct that neither referral supplied satisfied the DHB criteria for proceeding with gastroscopy, and there was no request for colonoscopy. It must be noted that [Mrs B] maintained her haemoglobin well within the normal range throughout 2016.

13. In the first quarter of 2017 there were no consultations related to [Mrs B's] bowel symptoms. She was seen mainly for psychological issues and follow-up of a leg fracture. There was ongoing respiratory specialist review.

14. On 27 April 2017 [Mrs B] saw [Dr A] in relation to ongoing back pain issues and possible forthcoming spinal surgery. [Dr A] states that towards the end of the consultation [Mrs B] mentioned her irregular bowel habit … *I had been aware that she had intermittent abdominal pains over many years with alternating constipation and diarrhoea. She did not mention any associated PR blood loss. The chronology that she described to me was of several years of irregular bowel habit with episodes of pain going back prior to her last pregnancy. In light of her long history of irregular bowel habit, I advised treatment for irritable bowel syndrome with the proviso that if she did not have a satisfactory response, she would need blood and stool tests and possibly a Gastroenterology review.* Clinical notes include: *Has IBS symptoms past 2 years inc explosive diarrhoea and lower abdo pain … Rx IBS — if not satisfactory response to rx will need further blood and stool ix and possibly gastroenterology review.* There is no examination documented. Trial of colofac and amitriptyline prescribed.

Comment: [Mrs B] apparently described a change in bowel pattern of two years' duration on a background of longer-term irregular bowel pattern. [Dr A] did not gain a history of persistent PR bleeding but it is unclear if [Mrs B] denied this symptom or did not volunteer it. I would expect the patient to be asked directly regarding the presence of rectal bleeding and I would be moderately critical if this was not done. While the symptoms described could be consistent with an IBS diagnosis, particularly in [Mrs B's] age group, the presence of PR bleeding would require reconsideration of such a diagnosis. [Mrs B] had been under considerable psychological stress in the previous 12 months and this was ongoing which could be regarded as significant with respect to an IBS diagnosis. Her weight was increasing rather than decreasing. Her most recent haemoglobin in September 2016 was normal but ferritin had remained low. Assuming there was no history of ongoing rectal bleeding, I think a diagnosis of IBS was not unreasonable on the basis of the recorded history provided the red flag of progressive iron deficiency anaemia was excluded[6]. I believe best practice would have been to examine the patient's abdomen (which is likely to have been normal), refer for CBC and iron studies and determine a suitable management plan based on the results. It was reasonable to commence a trial of IBS treatment in the interim. The failure by [Dr A] to

[6] BPAC. Irritable bowel syndrome in adults: Not just a gut feeling. Best Practice Journal. 2014; Issue 58 https://bpac.org.nz/BPJ/2014/February/ibs.aspx Accessed 9 July 2020

check for the red flag of progressive iron deficiency anaemia at this point, particularly given [Mrs B's] past history, I would regard as a mild to moderate departure from accepted practice. If [Mrs B] had admitted to persistent rectal bleeding at this consultation, I would be moderately critical of the failure to undertaken an examination (abdominal and DRE) and to refer for blood tests as described.

15. There is no reference to iron tablets being prescribed in the first half of 2017. CBC (no ferritin) on 6 June 2017 (ordered by dermatologist) showed decreased haemoglobin from previous results (although still within normal limits) and borderline hypochromia. [Dr A] reviewed [Mrs B] on 7 June 2017. Ongoing major psychological stressors were discussed and documented initially. [Dr A] then documented:

often has urgent bowel action in morning — occ 4–5 times — will wake at night with bad abdo pain and then has loose bowel motion/green water and offensive smell

no clear pattern — BO — 20–30 times per day

occ passes blood and mucus as gets mucus discharge

feels very bloated — no obvious food precipitants ie dairy/gluten

symptoms over past 2 years but worse past 2–3 m

amitriptyline has helped sleep but not bowel habit

bloods and faecal calciprotectin and will refer gastro once have results

? IBD or IBS

There is no record of a physical examination. [Dr A] states in his response that he examined [Mrs B's] abdomen but deferred her DRE because of her current psychological distress (which was of a sensitive nature) … *I instead asked [Mrs B] to return for a fuller examination including the rectal examination after she had done some blood and stool tests.* Lab forms were provided for faecal calprotectin and culture, CBC and CRP. [Mrs B] did not get the investigations done and was not seen by [Dr A] again until 22 August 2017. CBC results dated 18 July 2017 (ordered by respiratory physician, copy to [Dr A]) showed a further drop in haemoglobin to borderline levels with hypochromia and microcytosis now evident consistent with iron deficiency. The results were annotated '[Dr A's initials]' with no further comment.

Comments:

(i) There were features of [Mrs B's] presentation at this point that were not consistent with IBS — rectal blood loss and abdominal pain waking her at night. Bowel frequency had apparently increased markedly in the previous two to three months and a frequency of 20–30 times daily is clearly abnormal. There was no associated weight loss or anorexia. CBC result received the previous day showed haemoglobin within the normal range but decreased from previously with borderline hypochromia. It was

certainly appropriate to consider a diagnosis other than IBS and [Dr A] has noted a differential of inflammatory bowel disease (IBD) and initiated investigations to confirm this diagnosis. I think it was reasonable to defer a physical examination that day under the circumstances described, but I believe it was imperative that [Dr A] arranged to track [Mrs B's] blood and faeces results to ensure they were undertaken in a timely manner, and physical assessment was also completed in a timely manner once [Mrs B] felt more comfortable with this. I believe the intended management plan was reasonable as documented, but the failure by [Dr A] to ensure the plan was completed in a timely manner was a moderate departure from accepted practice. Given the severity of [Mrs B's] symptoms, it might have been assumed she would be keen to find a diagnosis and treatment and it is somewhat difficult to explain why she did not adhere to the management plan. Nevertheless, the clinical picture was sufficiently suspicious for significant colorectal pathology, whether IBD (most likely) or CRC (less likely given [Mrs B's] age), to warrant tracking of the management plan. [Mrs B] may at this stage have fulfilled the criteria for direct access to outpatient colonoscopy on the basis of suspected moderately severe IBD, but positive faecal calprotectin was probably required to facilitate the investigation. If DRE had shown a palpable lesion (as it did six months later) urgent referral with high suspicion of cancer would have been mandatory. There was a missed opportunity to follow-up [Mrs B's] non-adherence to the plan when CBC results received on 18 July 2017 suggested progressive iron deficiency. Best practice would have been to determine any family history of CRC as discussed in section 11(i) and I am mildly critical this was not done.

(ii) [Dr A] has outlined in his response his reflections on this case and changes he has made to his practice as a consequence of this review. The changes appear appropriate and should go some way towards reducing the risk of such diagnostic delay in the future. It may also be of value for [Dr A] to reflect on the cognitive errors common to all clinicians (myself included) which contribute to diagnostic delay and an excellent RACP presentation on this subject is cited below[7].

16. [Mrs B] saw another provider at [the medical centre] on 13 August 2017 for back issues. She saw [Dr A] on 22 August 2017 for similar issues (she was currently awaiting back surgery which was undertaken the following month). There is no reference to discussion of ongoing bowel issues at these consultations, and passing reference to 'stable IBS symptoms' in the neurosurgical pre-admission assessment (see s7). On 25 September 2017 [Dr A] reviewed [Mrs B] following her back surgery in relation to pharyngitis. On 24 October 2017 a haematology letter was received noting [Mrs B's] ongoing iron deficiency (see s9 last bullet point) annotated by [Dr C] as *ET, iron deficiency. For 3/12 iron replacement.* Another [medical centre] provider reviewed [Mrs B] on 26 October 2017 in relation to laryngitis and she saw provider … at [the medical centre] on 18 January 2018 with herpes simplex infection. There is no reference to complaint of ongoing bowel symptoms at any of these consultations.

[7] https://www.racp.edu.au/docs/default-source/Events/congress-2017-presentations/racp-17-tue-scott-heslop.pdf?sfvrsn=2 Accessed 9 July 2020

17. [Mrs B] attended [Dr F] at [the medical centre] on 25 January 2018. Notes include:

Tailbone has been very sore for the last 3–4 months. Constant pain regardless of position. No exacerbating or relieving factors. No hx of injury. No radiation. Dose not feel like her previous back or sciatic pain. Nearly went to hospital the other night because of the pain. Describes the pain as an intense burning ache. No new leg symptoms

Became severely constipated 10 days ago; needed to use an OTC enema. Currently passing small bowel movements daily — the stool can be hard or mucousy. Sensation of incomplete emptying. Can feel as if she he desperate to move her bowel, then nothing happens when she goes to the toilet. Has had loose stool for many years — usually stools between 10–20 times daily. Passed completely unformed stool for 99% of the times. Often has bright red or darker red blood in the toilet bowl — the blood can be sprayed round the bowl. Unable to go too far from her house because of her bowel.

Family Hx. Paternal aunt had bowel cancer in her 40s, paternal gmother had bowel cancer in her 40s.

Long standing microcytosis. Has been on iron replacement for months

Regular periods, very heavy bleeding for the first 3 days.

Hx of CIN II 2003, treated with a LLETZ procedure. Normal smears since 2005.

Last smear Sep 2013.

o/e abdo bloated, soft, non-tender, no masses, no lkks

DRE — soft polypoid mass felt with fingertip at site would expect to feel cervix, tender, blood on glove fingertip, nil seen with proctoscope

speculum exam — old cervical scarring, normal appearance post LLETZ VE — NAD

Imp: rectal bleeding, abnormal bowel habit, rectal mass, pain around the coccygeal area

Plan: discussed findings with [Mrs B]. Bloods. Urgent surgical referral.

Will take tramadol for pain relief, with prn laxative.

Comment: [Dr F] obtained a comprehensive and appropriate history and undertook a comprehensive and appropriate assessment. Her standard of clinical documentation was excellent. Her management of [Mrs B] on 25 January 2018 was consistent with accepted practice.

18. [Mrs B] subsequently underwent further investigations and was diagnosed with stage IVB CRC. She underwent neoadjuvant chemoradiotherapy followed by surgery and palliative chemotherapy/radiotherapy. Sadly, she succumbed to her disease [in 2019] at the age of … years. My thoughts go out to her family at their tragic loss."

Further advice from Dr Maplesden

"I have reviewed responses to my original advice from [Dr C] and [Dr A].

1. Response [Dr C]

Regarding the consultation of 10 November 2015 (section 11 in original advice), [Dr C] advises the following:

(i) [Dr C] notes [Mrs B's] family history of bowel cancer was not established until close to the time of her diagnosis despite her seeing multiple clinicians in the intervening period. I believe that asking about a family history of bowel cancer certainly represents best practice in any patient presenting with rectal blood loss and unexplained weight loss and the failure by [Dr C] to do this represents a departure from best practice. However, taking into account [Mrs B's] age, the outlet-type bleeding she described and the impression given in [Dr E's] letter that the weight loss had been previously investigated, the failure to establish the family history at this time was perhaps not a departure from common practice.

(ii) [Dr C] is confident she undertook an abdominal examination but as it was normal, she did not record the absence of abnormality. She is confident such an examination was performed because she invariably examines a patient's abdomen before performing a rectal examination, and rectal examination was recorded at the consultation in question. I accept that [Dr C] did perform an abdominal examination. However, in my experience of reviewing clinical notes it is common and accepted practice to document the findings of an abdominal examination even when normal when such an examination is performed in patients with GI symptoms and I am mildly critical this documentation was omitted.

(iii) [Dr C] defends her management plan following her assessment of [Mrs B] on 10 November 2015 noting: an impression (from the specialist letter) that [Mrs B's] weight loss had been previously investigated; she established there were a number of possible causes (none obviously sinister) for the iron deficiency; she acknowledged (and documented) that it was likely surgical referral would be required but organised further investigations (blood tests) initially which were somewhat reassuring; she states it is likely (as this is her usual practice) that she instructed [Mrs B] to return for review should her rectal bleeding symptoms persist or worsen; when conveying the blood results to [Mrs B], the practice nurse (on [Dr C's] direction) conveyed to [Mrs B] the need to come in for review following her impending surgery and this was documented in the notes and visible to the usual GP. I believe these factors indicate there was a reasonable management plan in place although aspects such as safety-netting advice may have been more clearly documented. However, I am also aware of the content of the specialist letter which led to [Mrs B's] presentation to [Dr C], and which recommended gastroenterology referral *unless there are very good explanations for both her iron deficiency and her weight loss.* I remain of the view that it would have been best practice to make such a referral following receipt of the blood tests results

(although I cannot state the referral would necessarily have been accepted) but taking into account the clarifications from [Dr C], including the reasonable expectation that [Dr A] would refer as appropriate following the review [Mrs B] was advised to attend, I reassess [Dr C's] management as reasonable under the circumstances described and retract my previous mild to moderate criticism.

2. Response [Dr A]

(i) The failure to recheck ferritin levels prior to re-prescribing oral iron on 16 March 2016: [Dr A] describes his rationale for deferring further testing as the ferritin levels and haemoglobin were stable and there were factors other than GI blood loss which could account for the results (poor absorption, menorrhagia which was recorded at a consultation on 28 April 2016). I note [Dr A] had recorded on 25 November 2015 an intention to make a gastroenterology referral if [Mrs B's] ferritin had not improved and this was consistent with the recommendation from the haematologist in November 2015 and that from [Dr E] in October 2015. The results from 16 March 2016 showed a drop in haemoglobin from previous results and no change in ferritin ie there was no response to the course of iron replacement. I believe referral for gastroenterology assessment was indicated and remain mildly critical this was not done although it is possible the referral would have been declined as it was later.

(ii) Consultation of 27 April 2017: [Dr A] is confident he would have asked [Mrs B] regarding rectal bleeding symptom at this consultation as, had it been present as an ongoing symptom, his provisional diagnosis and management plan would have been quite different to that documented. Because the symptoms described were consistent with IBS with no rectal bleeding, [Dr A] did not see the need to check for progressive iron deficiency. Furthermore, patients with isolated hypoferritinaemia without a high index of suspicion for serious pathology were not being accepted for endoscopy at this time. I remain of the view that an abdominal examination would have represented best practice at this time (and would be expected together with rectal examination if [Mrs B] had complained of rectal bleeding symptom) and that documentation of the important negative symptom of absence of rectal blood loss also represents best practice in the situation described. However, if there was no symptom of bleeding, I retract those criticisms related to the presence of this symptom. Noting the last blood tests were seven months previously and had shown persistently low ferritin and [Mrs B] was now presenting with concern about lower GI symptoms (even if not new), I remain mildly critical that the tests were not repeated at this consultation to exclude progressive iron deficiency.

(iii) Consultation of 7 June 2017: [Dr A] emphasises the primary reason for [Mrs B's] consultation on this date was for psychological distress. Bowel symptoms were discussed in the latter part of the consultation and a management plan agreed — further testing to exclude IBD and review with results and rectal examination in the near future. [Dr A] wasn't aware [Mrs B] had had blood tests performed the previous day (ordered by the dermatologist) and when the results were reviewed and did not appear alarming, [Dr A] thinks he ticked the task reminder (for the tests he had ordered) as

being completed and there was therefore no alert for the outstanding tests which had yet to be performed. I remain of the view that the clinical picture presented by [Mrs B] on 7 June 2017 was sufficiently suspicious for significant clinical pathology (whether IBD or CRC) that performing an abdominal and rectal examination was critical. In the circumstances described a short-term deferral of the examination was not unreasonable, but tracking of completion of the physical examination and referral was warranted and I remain moderately critical of the failure to do this effectively. While the single CBC result appearing about this time and being interpreted by [Dr A] as the tests he had ordered might be regarded as a mitigating factor, there is nothing to suggest [Mrs B] was contacted regarding the result to state it had been received and to schedule the intended review. I think this was a weakness in [Dr A's] tracking process at the time and the changes in clinical practice he has outlined in his responses should ensure more robust tracking in the future. I acknowledge the patient factors contributing to the delay in diagnosis from this time (recommended tests not performed and no presentation with ongoing or worsening bowel symptoms over the next seven months). However, given the complex nature of [Mrs B's] presentation on 7 June 2017 with her priority being psychological distress unrelated to her bowel issue, I think it was important to ensure the psychological issues did not distract him from the importance of addressing the bowel issues and robust tracking of the intended management plan (particularly completion of an appropriate clinical examination including DRE) should have been a priority."

Appendix B: Relevant standards

Management of Clinical Investigations Policy (dated 29 March 2017)

"… **3. Clinical Correspondence, test results and other investigations received via mail:**

… Tracing Results and Clinical Referrals
The practice is committed to ensuring that patients have clinical investigations and referrals attended to in a timely manner.

Patients will be advised at the time of referral to contact the Health Centre Nurses Clinic if they have not heard from the organisation referred to within a specified timeframe. Providers will be able to give patients some indication of what is a reasonable timeframe.

For test results:

In addition, the providers will use the taskbar messaging system as a back up.

The task bar reminds the provider who ordered the test if the result has not returned.

The patient should then be contacted by text message, phone or mail — there is a letter for this purpose in the 'Out' box called 'Test X' and a text message called 'Txtdo' …"

Minimum Standards for Clinical Communication policy (dated 30 November 2016)

"Inbox laboratory and radiology results

- Inbox to be checked by GP at once per session on the days they are working and results dealt with in a timely manner. Urgent results which have not already been addressed are to be dealt with immediately (e.g. troponin, d-dimer), and other significantly abnormal results within 48h. Comment to be added, and classifications, as necessary. Results are to be filed. If result viewed but not filed, comment such as 'thinking about this' will aid nurses if patient phones for results.

- Inbox should not contain unannotated results older than two weeks. In this case, GP may have time set aside for them to clear their inbox."