General Practitioner, Dr C

Medical Centre

A Report by the

Health and Disability Commissioner

(Case 17HDC02317)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. Between June 2016 and February 2017, Ms A presented to a medical centre on four separate occasions.

2. Ms A was seen by Dr C, her regular GP at the time, on 2 June 2016 and 19 August 2016. At the first appointment, she presented with perianal itch and irritation. No examination was performed, and Dr C suggested she try Proctosedyl ointment. By the second appointment, the external anal itch had settled, but she had noticed blood on toilet paper after wiping. A perianal examination was performed, and Dr C concluded that a haemorrhoid was likely and prescribed suppositories. A digital/internal examination was not performed, as Dr C considered that this would have been too painful for Ms A.

3. On 30 November 2016, Ms A attended an appointment with Dr D. Ms A had been experiencing intermittent bleeding from her rectum but no changes to her bowel habits. The clinical notes record that a rectal examination was declined, and suppositories and anti-nausea medication were prescribed.

4. On 10 February 2017, Ms A attended an appointment with Dr C for ongoing bleeding from her rectum and change to her bowel habits. Dr C explained that no examination was performed as his attempt previously had been too painful for her, and she had declined an examination from Dr D. Dr C believed that Ms A had haemorrhoids, and an examination would not have changed the treatment plan. He discussed with Ms A a referral to the public hospital and ordered blood tests. After receiving Ms A's abnormal liver function results, he completed the referral.

5. Ms A was reviewed at the public hospital on 10 April 2017, where an examination revealed a palpable liver mass and a mass above the anal canal, which was later diagnosed as rectal cancer.

Findings

6. By failing to perform a rectal examination at the appointment on 10 February 2017, Dr C did not provide Ms A services with reasonable care and skill and, accordingly, breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

7. The medical centre was not found vicariously liable for Dr C's breach of Right 4(1).

Recommendations

8. It was recommended that Dr C provide a written letter of apology to Ms A's daughter for the breach of the Code identified in this report, and provide to HDC evidence of the learnings from the bowel cancer update he has included as part of his Professional Development Plan with the Royal New Zealand College of General Practitioners.

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

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Complaint and investigation

9. The Commissioner received a complaint from Ms A about the services provided by Dr C at a medical centre. The following issues were identified for investigation:

- *Whether Dr C provided Ms A with an appropriate standard of care between 2016 and 2017.*
- *Whether the medical centre provided Ms A with an appropriate standard of care between 2016 and 2017.*

10. The parties directly involved in the investigation were:

Ms A	Consumer/complainant (dec)
Ms B	Complainant/executor of Ms A's estate
Dr C	General practitioner/provider
Medical centre	Provider

Also mentioned in this report:

Dr D	General practitioner

11. Information from the district health board was also reviewed.

12. Independent expert advice was obtained from Dr Gerald Young, a general practitioner, and is included as Appendix A.

Information gathered during investigation

Introduction

13. At the time of these events, Ms A (then aged 54 years) had been a patient of Dr C at the medical centre for about 20 years.

Consultations between June 2016 and February 2017

14. On 2 June 2016, Ms A attended an appointment with Dr C as she had been experiencing perianal itch and irritation. No examination was performed, but Dr C suggested that she try Proctosedyl[2] ointment and return for an examination. However, the clinical notes do not document that a follow-up appointment was made at this time.

15. Ms A next attended an appointment with Dr C on 19 August 2016. The external anal itch she had been experiencing previously was noted to have settled, but Ms A reported that she had noticed blood on the toilet paper after wiping. Dr C performed a perianal

[2] Ointment used to reduce haemorrhoidal swelling, pain, and inflammation.

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examination[3] and noticed excoriation,[4] skin tags, and a lump. He concluded that a haemorrhoid was likely, and prescribed suppositories. He told HDC that he did not perform a digital/internal examination as Ms A's anus was very tender, and this would have been too painful for her. There is no record in the clinical notes that an internal examination was discussed with Ms A.

16. On 30 November 2016, Ms A attended an appointment with Dr D at the medical centre. Contemporaneous notes record that a rectal examination was declined. Notes from this appointment record that Ms A had been experiencing intermittent bleeding from her rectum but had not noticed any changes in her bowel habits. Suppositories and ondansetron, an anti-nausea medication, were prescribed. Clinical notes state that the suppositories had helped.

17. On 10 February 2017, Ms A attended an appointment with Dr C and reported ongoing bleeding from her rectum and a change in bowel habits. It was noted that she was still having "trouble with haemorrhoids, blood most times, goes up to 3 x day". No examination was performed. Dr C explained that this is because his attempt on her first visit had been too painful for her, and subsequently she had declined an examination with Dr D. Dr C said that at the time he believed that Ms A had haemorrhoids, and an examination that day would not have changed the treatment plan. Dr C told HDC that he considered a referral to the surgical clinic at the public hospital for further investigation, and discussed this with Ms A. However, there is no record of that conversation in the notes. Dr C ordered blood tests, which revealed that Ms A's liver function was abnormal, with elevated C-reactive protein (CRP)[5] and lipids.[6]

18. On 15 February 2017, after having received Ms A's blood tests, Dr C completed a referral to the public hospital.

19. On 10 April 2017, Ms A was reviewed at the public hospital, where an examination revealed a palpable liver mass and a mass above the anal canal, which was later diagnosed as rectal cancer.

Further information — Dr C

20. Dr C told HDC that he accepts that the result of not having performed an internal examination at the appointment of 10 February 2017 meant that there was a delay in Ms A being reviewed at the public hospital, but he is of the view that the delay must be placed in the context of the overall timeframe of Ms A's symptoms.

21. Dr C told HDC that he apologised to Ms A for this in person.

[3] Examination of the area around the anus.
[4] Scratches or breaks in the skin surface.
[5] A substance produced by the liver in response to inflammation.
[6] Fats.

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22. Dr C also told HDC that he has included bowel cancer as part of his Practice Development Plan with the Royal New Zealand College of General Practitioners (RNZCGP).

Further information — the medical centre

23. The medical centre told HDC that at the time of events it was guided by the recommendations of RNZCGP, which include a policy on delayed diagnosis of cancer. The medical centre achieved certification with RNZCGP. As part of this, the medical centre updated all its policies and procedures, including developing and implementing procedures in respect of patient records, a clinical record audit process, and a quality audit plan (an annual audit of all clinical notes).

Responses to provisional decision

Dr C

24. Dr C was given an opportunity to comment on the provisional decision. He accepts the finding. He stated that he regrets not carrying out a rectal examination and, with the benefit of hindsight, acknowledges that this may have contributed to the delay in diagnosis.

Ms B

25. Sadly, Ms A passed away. Ms B, Ms A's daughter and executor of her estate, was given an opportunity to comment on the "information gathered" section of the provisional decision, but did not provide a response.

The medical centre

26. The practice was given an opportunity to comment on the provisional decision, but did not provide a response.

Relevant standards

27. The Medical Council of New Zealand's publication *Good Medical Practice — A guide for doctors (2008)* states:

> "…
>
> Medical care
>
> Good clinical care — a definition
>
> …
>
> 2. Good clinical care includes:
>
> …
>
> - Providing or arranging investigations or treatment when needed
> - Taking suitable and prompt action when needed …"

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Opinion: Dr C — breach

Consultations on 2 June 2016 and 19 August 2016

28. At the appointment on 2 June 2016, Dr C suggested that Ms A try Proctosedyl ointment and return for an examination.

29. My expert advisor, Dr Gerald Young, advised:

> "The assessment and management is a reasonable standard of care in this circumstance. It is a common practice to provide treatment for common problems such as perianal itch/irritation and review depending on response to treatment."

30. At the appointment of 19 August 2016, Dr C performed a perianal examination and concluded that a haemorrhoid was likely, and prescribed suppositories.

31. Dr Young advised that this consultation, assessment, and management was of a reasonable standard of care as documented.

32. I accept Dr Young's advice, and am satisfied that, in the circumstances, Dr C did not depart from a reasonable standard of care in respect of the appointments of 2 June and 19 August 2016.

Consultation on 10 February 2017

33. When Dr C reviewed Ms A on 10 February 2017, he noted that she was still having "trouble with haemorrhoids, blood most times, goes up to 3 x day". She was still feeling tired and she had ongoing back pain. The clinical records document that she was not examined that day, but do not record a reason why. Dr C told HDC that he considered a referral to the public hospital surgical clinic for further investigation, and discussed this with Ms A. However, this was not documented in the clinical notes.

34. Dr Young advised:

> "A clinical exam should have been done of the abdomen including a rectal exam and proctoscopy if indicated after the internal rectal exam. [Ms A] disclosed continuing PR bleeding and now changes in bowel habit going three times per day. [Dr C] was aware that no rectal examination had been done to date. The rectal exam would have revealed the rectal tumour that was growing just inside the anal margin."

35. Dr Young notes that a finding of a rectal tumour would have increased the urgency and priority of Ms A's referral and of her being seen at the hospital, but acknowledges that the clinical outcome may have been the same.

36. I find that by failing to perform a rectal examination at the appointment on 10 February 2017, Dr C did not provide Ms A services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

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Clinical notes — other comment

37. Dr Young advised:

> "If the internal exam was not done then the reason(s) why should be noted so that there is no confusion over whether it had been performed or not, if consulted by another practitioner. [Dr C's] clinical notes were brief, whilst they may have sufficed to remind himself of the consultation events, it was hard to know the exact details of what occurred without his additional commentary, for example his reason for not doing an internal exam on the 19-Aug-2016 consultation or any clinical exam at the consultation of 10-Feb-2017. The need for recorded clinical details is important in a group practice setting when more than one practitioner may see each patient."

38. I accept Dr Young's advice and agree that Dr C's clinical notes should have detailed why an internal examination was not performed.

Opinion: Medical centre — no breach

39. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. In this case, I consider that the omission that occurred did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

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

41. At the time of the appointment of 10 February 2017, Dr C was an employee of the medical centre. Accordingly, the medical centre is an employing authority for the purposes of the Act. As set out above, I have found that Dr C breached Right 4(1) of the Code for failing to offer Ms A a rectal and abdominal examination at the appointment on 10 February 2017.

42. The medical centre was guided by the recommendations of RNZCGP. I note that these included a policy regarding a delayed diagnosis of cancer. In my view, the medical centre took such steps as were reasonably practical to ensure that such errors did not occur. Accordingly, I do not find the medical centre vicariously liable for Dr C's breach of the Code.

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Recommendations

43. I recommend that Dr C provide a written letter of apology to Ms B for the breach of the Code identified in this report. The apology letter should be sent to HDC within three weeks of the date of this report, for forwarding to Ms B.

44. In response to the provisional decision and proposed recommendations, Dr C provided evidence of the learnings from the bowel cancer update he has included as part of his Professional Development Plan with the Royal New Zealand College of General Practitioners.

Follow-up actions

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

46. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, and it will be advised of Dr C's name.

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

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Gerald Young, a general practitioner:

"I have been asked to provide specific advice regarding whether the care provided to [Ms A] by [Dr C] […]was reasonable in the circumstances, and why.

In particular, please comment on:

1. Whether the assessments or examinations undertaken at each of her presentations at [the medical centre] were appropriate.
2. Whether there was any indication for an earlier referral to [the public hospital] or any other service.

In preparing the advice on this case to my knowledge I have no personal or professional conflicts of interest giving advice in this case.

References provided to complete the report:

1. Letter of complaint dated […].
2. [Dr C's] response dated 2 February 2018.
3. Clinical records from [Dr C] covering the relevant period.
4. Comment from [the DHB] dated 26 January 2018.
5. Clinical records from [the DHB] covering the relevant period.

Other reference used:

6. 'General Practice' — John Murtagh — McGraw-Hill 1994 pages 254–256 (Rectal bleeding).

Advice:

A. Consultations and examinations:

1. 02-Jun-2016. [Dr C]; At this consultation the complaint was recorded as 'perianal itch, irritation. Also bulge in vagina with defaecation. No stress or urge incontinence.' It was noted that [Ms A] had 4 pregnancies and had a hysterectomy over 10 years ago.

No exam was done at that time, but a note was made 'for Rx (treatment/script) and then review for exam'. The time frame for the 'review for exam' was not stated.

The assessment and management is a reasonable standard of care in this circumstance. It is a common practice to provide treatment for common problems such as perianal itch/irritation and review depending on response to treatment. Ideally a time for review and examination if the treatment had not been effective should have been given. This may have been done but not recorded or that it was understood that it would be reviewed at [Ms A's] next routine visit.

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2. 19-Aug-2016 [Dr C]; The main presenting complaint documented was back pain that was associated with a lifting injury. The external anal itch was noted to have settled but blood was reported on the paper.

The perianal examination revealed 'excoriation, skin tags and int haemorrhoid'. Treatment with ultraproct suppositories was prescribed.

With the finding of excoriated perianal skin this could be the cause of the blood on the toilet paper. The haemorrhoid was recorded as being internal on the notes but [Dr C], in his letter of reply, states that this was an external haemorrhoid. An external haemorrhoid can also be a cause of blood on the paper if it has ruptured.

This consultation, assessment and management was a reasonable standard of care as documented.

If the additional complaints as listed by [Ms A], bleeding, pain, foul wind, tiredness and vaginal prolapse was raised then additional questioning would have been expected of these symptoms. Additional examinations would have been expected, the exact nature of what further examinations would have been appropriate would have depended on the responses to further questioning about the symptoms. They may have included an abdominal exam including vaginal examination for the prolapse. Whether an internal rectal exam and proctoscopy would have been indicated is again dependent on details that would have needed to have been elicited for the symptoms. If the 'bleeding' was as noted on the paper only then an internal with proctoscopy was not required.

If the bleeding was different in nature, especially if it was mixed in with the stools, black or dark blood noted, and/or associated with bowel changes then further investigations would be warranted. There is some doubt if an internal rectal exam and proctoscopy could have been performed at that time in any case, as [Dr C] noted in his reply that at the time [Ms A] had significant anal tenderness so an internal was not attempted.

If tiredness was raised with the bleeding then blood tests would have been appropriate, in particular to check her haemoglobin levels and iron levels as well as other possible causes of tiredness that can be detected in a blood test.

3. 30-Nov-2016 [Dr D]; 'Intermittent pr bleed' was noted. It was recorded that the bleeding occurred associated with 'passing BM or passing flatus at times. Unsure of exact amount but mostly on toilet paper on wiping. finds it hard to quantify. doesn't think she has passed any black BMs. bowel habits have not changed. Has been passing more wind, feeling nauseated at times. no appetite or weight Change. maternal granddad had bowel cancer aged 70s. [Ms A] does have known vaginal prolapse apparently — says lump extrudes 1–2cm out of vagina.'

This detailed record of the history reveals that the PR bleeding is not associated with any bowel changes or weight loss. The blood is mostly on the paper and there is no dark blood.

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[Dr D] noted that [Ms A] looked well and was pain free at that time. It was documented that [Ms A] 'declined pr exam for now'.

A detailed plan of management was recorded; that suppositories would be trialed again as they did help. [Ms A] would 'monitor the PR blood loss inc [including] amounts. If any black BMs or changes in bowel habits. if so. will return for review ?colonoscopy if indicated.'

Other advice was given on dietary modifications that could be tried to help her nausea. It was agreed to leave any active management of her vaginal prolapse at this stage until her gastrointestinal problems had been sorted.

It is noted that [Dr D] was not [Ms A's] regular GP. [Dr D] may have relied on [Dr C's] previous record of 19-Aug-2016 that he had diagnosed '… int haemorrhoids'. It would have been reasonable for [Dr D] to assume that [Dr C] had done an internal rectal exam and/or proctoscopy to have made that diagnosis. With a rectal exam having been performed just 3 months earlier and the diagnosis of internal haemorrhoids made, with no significant new symptoms disclosed it would be understandable [Dr D] didn't debate with [Ms A] the necessity for a PR examination at that time.

A clear management plan was discussed with [Ms A] including follow up actions if the problems did not settle.

[…]

4. 10-Feb-2017 [Dr C]; it was noted that [Ms A] was still having '… trouble with haemorrhoids, blood most times. goes up to 3 x day.' She was also still feeling tired. Her back pain was ongoing. She had been to see the physio who recommended weight loss. She reported that she had been walking daily.

The clinical records document that [Ms A] was 'not examined again today', blood tests were ordered. No reason was given for why a clinical examination was not done. There was no mention that [Ms A] declined an examination in the records nor in the letter of reply from [Dr C] to the complaint.

A clinical exam should have been done of the abdomen including a rectal exam and proctoscopy if indicated after the internal rectal exam. [Ms A] disclosed continuing PR bleeding and now changes in bowel habit going three times per day. [Dr C] was aware that no rectal examination had been done to date. The rectal exam would have revealed the rectal tumour that was growing just inside the anal margin.

The finding of a rectal tumour would have increased the urgency and priority that [Ms A] should have been referred and would have been seen at the hospital as opposed to a referral for haemorrhoids and elevated liver tests that was sent five days after the consultation.

I accept the clinical outcome may well have been the same but it would have spared [Ms A] from the additional waiting time of two months that occurred.

The standard of care was a moderate departure from a reasonable standard of care.

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B. Whether there was any indication for an earlier referral to [the public hospital] or any other service?

As discussed in each of the individual consultations above earlier referral was not indicated if the clinical records correctly documented each encounter. Early referral would have been indicated if the internal rectal exam had been performed and the rectal tumour was felt at the consultations of 19-Aug-2016 and 30-Nov-2016. It was stated that [Ms A] was too tender to be able to perform an internal exam on 19-Aug-2016 and declined to be examined on 30-Nov-2016. An abdominal and internal rectal exam should have been done at the consultation of 10-Feb-2017. The referral could have been made immediately as an urgent referral with the findings of a rectal tumour and it would have increased the urgency that [Ms A] would have been seen, as opposed to the referral that was done five days later on the 15-Feb-2017.

The fact that the rectal tumour was very low, situated just inside the anal canal meant that any bleeding from the tumour could have mimicked haemorrhoidal bleeding being fresh and bright red. Conversely being low just above the anal canal meant the tumour would have been palpable on internal exam.

As a general rule with any PR bleeding a perianal/rectal examination with internal exam should be done and proctoscopy if indicated for PR bleeding, so that the source of the bleeding is identified. Where the patient declines the exam or it is clinically too painful to perform the exam, a clear plan of treatment outcome expectations should be discussed and review period defined if the PR bleeding or symptoms have not settled.

If the internal exam was not done then the reason(s) why should be noted so that there is no confusion over whether it had been performed or not, if consulted by another practitioner. [Dr C's] clinical notes were brief, whilst they may have sufficed to remind himself of the consultation events, it was hard to know the exact details of what occurred without his additional commentary, for example his reason for not doing an internal exam on the 19-Aug-2016 consultation or any clinical exam at the consultation of 10-Feb-2017. The need for recorded clinical details is important in a group practice setting when more than one practitioner may see each patient.

Please contact me if any part of my opinion requires clarification.

Yours sincerely,

Dr Gerald Young."

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