HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC02347)

Introduction

1. 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.

2. The report discusses the care provided to Mr A by Health New Zealand|Te Whatu Ora (Health NZ) Capital, Coast and Hutt Valley[1] and Dr B in relation to a delayed diagnosis of rectal cancer. Sadly, Mr A passed away in 2024.

3. The following issues were identified for investigation:

- *Whether Health New Zealand Capital, Coast and Hutt Valley provided [Mr A] with an appropriate standard of care between 4 August 2016–18 November 2020 (inclusive).*
- *Whether [Dr B] provided [Mr A] with an appropriate standard of care on 18 November 2020.*

4. The parties directly involved in the investigation were:

Dr B	Medical officer/provider
Dr C	Medical officer/provider
Mrs D	Complainant/consumer's mother
Health NZ Capital, Coast and Hutt Valley	Provider

5. Other aspects of Mrs D's complaint about additional providers involved in Mr A's care have been dealt with separately.

6. Independent advice was obtained from Professor Ian Bissett, a consultant general and colorectal surgeon and professor at the University of Auckland, Department of Surgery (Appendix A) and from medical officer Dr Stephen Adams (Appendix B).

[1] Formerly known as Capital, Coast and Hutt Valley District Health Board. On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Health New Zealand|Te Whatu Ora. All references in this report to Capital, Coast and Hutt Valley District Health Board now refer to Health NZ Capital, Coast and Hutt Valley.

Names (except Health NZ Capital, Coast and Hutt Valley and the independent advisors on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Background

7. In 2016 Mr A (aged 39 years) was referred to a public hospital with a history of rectal bleeding. He was diagnosed with haemorrhoids and received banding. A further referral was made in 2017, and Mr A underwent a haemorrhoidectomy[2] on 28 September 2017.

8. Mr A attended appointments at a medical centre in May and November 2020 for ongoing abdominal pain and diarrhoea. No further investigations were undertaken at this time, and on both occasions Mr A was encouraged to enrol with a GP for follow-up.[3] Subsequently Mr A was diagnosed with advanced rectal cancer in January 2021, and he passed away in 2024.

Responses to provisional opinion

Mr A's family

9. Mrs D was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion. She said that the family were pleased to see the improvements that had been made as a result of what happened to Mr A. Mrs D stated that Mr A had to file for bankruptcy in the years before his diagnosis, which put stress on his home life on top of dealing with his illness.

Dr C

10. Dr C was provided with an opportunity to comment on the provisional opinion as it related to him. Dr C told HDC that he accepts the comments in the report and subsequent learnings and has no further comment to make.

Dr B

11. Dr B was provided with an opportunity to comment on the provisional opinion as it related to her. She advised that she had no comments to make.

Health NZ

12. Health NZ was provided with an opportunity to comment on the provisional opinion. Its comments have been incorporated throughout the report where relevant.

Opinion: Health NZ Capital, Coast and Hutt Valley — breach

13. I take this opportunity to extend my sincere condolences to Mr A's whānau for their loss. I consider that deficiencies in the care provided by Health NZ Capital, Coast and Hutt Valley contributed to the delay in Mr A's diagnosis. I have set out the reasoning for my decision below, and I have addressed the care provided in chronological order, starting with the care provided at Public Hospital 1 and Public Hospital 2 in 2016 and 2017 before addressing the care provided by Dr C and Dr B and the medical centre in May and November 2020.

[2] A surgical procedure performed to remove haemorrhoids.

[3] Mrs D told HDC that Mr A was anxious about receiving medical care and did not always attend appointments. His work also meant that often he was away, and he did not enrol with a local GP.

4 August 2016

14. Following referral to Public Hospital 1, Mr A underwent haemorrhoid banding on 4 August 2016. Mr A's history of rectal bleeding was documented, along with the possibility of a palpable mass. A sigmoidoscopy[4] was not performed at this consultation.

15. Professor Bissett advised that a sigmoidoscopy would be an essential part of a patient assessment even when a prolapsing haemorrhoid is identified. The possibility of a rectal mass was also included in the reason for referral/differential section of the referral document, and Professor Bissett considers that in these circumstances, the failure to perform a sigmoidoscopy was at least a moderate departure from expected practice.

28 September 2017 & 8 November 2017

16. Mr A attended a further consultation at Public Hospital 2 on 28 September 2017 due to ongoing rectal bleeding and occasional spontaneous blood loss, and subsequently he was scheduled for a haemorrhoidectomy on 8 November 2017 at Public Hospital 1. A sigmoidoscopy was not performed on either of these occasions.

17. Professor Bissett considers that a sigmoidoscopy would be standard practice in the context of the second referral, given that it had been a year since the banding and there was evidence that the initial management of the haemorrhoids had not given any material improvement in Mr A's symptoms. Professor Bissett advised that not performing a sigmoidoscopy in these circumstances was a moderate departure from the accepted standard of care.

18. I accept this advice. While I acknowledge Professor Bissett's comment that it is speculative as to whether a sigmoidoscopy performed at any of these opportunities would have changed Mr A's clinical management, I am concerned that there were several missed opportunities at which a sigmoidoscopy was clinically indicated but not performed. I accept that multiple individuals were involved with Mr A over this time and, in my view, the responsibility for the deficiencies in care lay with Health NZ.

19. Accordingly, I find that Health NZ breached Right 4(1)[5] of the Code of Health and Disability Services Consumers' Rights (the Code) as multiple staff failed to perform a sigmoidoscopy at the consultations in 2016 and 2017.

Dr C — educative comment

20. Mr A attended one appointment with Dr C on 1 May 2020. Mr A's symptoms included abdominal pain and diarrhoea. Dr C's documented diagnosis was irritable bowel syndrome[6] (IBS). Dr C told HDC that his differential diagnosis was coeliac disease,[7] and he accepts that this should have been documented. Dr C considered that a stool sample was not appropriate

[4] An examination of the inside of the rectum and part of the large intestine.
[5] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[6] A group of symptoms that include abdominal pain and change in bowel movements without visible signs of damage or disease in the digestive tract.
[7] A chronic digestive and immune disorder that damages the small intestine and is triggered by eating gluten (a protein found in barley, wheat, rye, and oats).

given that the source of Mr A's diarrhoea appeared to be food related, and an FOBT[8] is not indicated in an acute setting, as per the bpac[nz] guidelines.

21. Independent advisor Dr Adams (Appendix B) raised two issues with the care provided by Dr C. First, Dr Adams advised that the single diagnosis of IBS considered by Dr C is a diagnosis of exclusion, which should be arrived at only after other possibilities have been explored. Dr Adams considered this to be a moderate departure from accepted practice but acknowledged that there were potential mitigating factors (discussed below) that might alter this finding.

22. Secondly, Dr Adams considered that a stool sample should have been taken. He advised that this is not a test for malignancy, it is a basic step in the diagnostic process for diarrhoea, particularly where it had lasted for over seven days, and he considered that this constituted a moderate departure from the expected standard of care, regardless of the final outcome. I note that Dr C considered that an FOBT was not appropriate in this case, but I am guided by Dr Adams, who advised that microscopic examination of a faecal sample was appropriate as opposed to an FOBT.

23. Dr Adams considers that both the departures identified were mitigated because of the medical centre's policy on blood testing, which discouraged further investigations (unless relevant to immediate management), and because Mr A was given clear advice to follow up with a GP.

24. I accept this advice. I note that Dr C did document that Mr A was told to follow up with a GP, and I consider that Dr C was limited in the further investigations that could be arranged given the medical centre's policies at the time. I consider that these mitigating factors reduce the severity of the departures from accepted practice. I note that Dr C has reflected on the standard of care provided, and I have no further recommendations.

Dr B — adverse comment

25. Mr A attended a second appointment at the medical centre on 18 November 2020 due to ongoing abdominal pain and diarrhoea and was seen by Dr B. Dr B did not examine Mr A but prescribed a short course of codeine and again advised him to enrol with a GP for follow-up. Dr B told HDC that this course of action was agreed with Mr A, although there is no documentation of this mutual agreement to defer care.

26. Dr Adams advised that given that it had been six months since Mr A's last consultation and Mr A was still having diarrhoea, which had not been diagnosed or investigated, Dr B should have examined Mr A and considered differential diagnoses, as the findings since his last consultation might have changed. Dr Adams concluded that this omission would be regarded as a moderate to severe departure from the standard of care.

27. I accept this advice. I note that Health NZ agrees that Dr B should have examined Mr A and documented a differential diagnosis, as set out in the medical centre's 'Orientation for

[8] Faecal occult blood test (a test for hidden blood in the stool).

Doctors' guideline.[9] I am concerned that this did not occur, particularly given that Mr A's symptoms had not improved, and he had not enrolled with a GP. However, noting the context in which Mr A was seeking care, via a medical centre, it is clear that the scope for follow-up was limited, and policies at the time reflected the expectation that a GP would be following up and making these diagnoses appropriately. Dr B appropriately advised Mr A of this limitation and the importance of enrolling with a GP in order to receive the test results for follow-up. Dr B sought agreement that Mr A would enrol with a GP to facilitate this process, and for this reason I do not find that Dr B breached the Code.

The medical centre — educative comment

28. At the time of these events, the medical centre had in place a blood test policy (Appendix C) along with the centre's 'Orientation for Doctors' document. The policy on blood testing sets out that laboratory or radiological tests are to be requested only for immediate management, while blood tests can be requested in certain circumstances.

29. Dr Adams advised that while it is reasonable for a medical centre to discourage long programmes of investigation, which should be managed by a patient's GP or appropriate specialist, it is reasonable for a centre to instigate early tests such as urine and faecal samples and baseline blood tests and pass the results and patient to a definitive investigator. In this case, the medical centre's policy defines tests as 'urgent' or 'non-urgent' and requires patients with urgent tests and non-enrolled patients with non-urgent tests to stay in the centre until results are available. Dr Adams advised that due to the practical difficulties (space in the waiting room, proximity to closing time, results not available the same day), this dissuades investigations and reduces the need for the centre to engage in follow-up and may cause the loss of an opportunity to make an early diagnosis.

30. In response to the provisional opinion, Health NZ told HDC that it accepts the comments regarding the approach to investigations at the medical centre, and changes have since been made to address these issues, as set out below.

31. I accept that there are difficulties with following up results for patients at a medical centre, as noted by the centre. However, I accept Dr Adams' advice that the medical centre has a responsibility to instigate some tests based on the clinical picture, and therefore the centre needs a system in place to ensure follow-up, particularly in the context of patients with no GP. I note that the centre has since made changes (discussed below) to address these issues, and I am satisfied that the steps taken by the centre are appropriate.

[9] The medical centre's 'Orientation for Doctors' sets out the following: 'Clinical documentation should meet the standards of the Royal New Zealand College of Urgent Care (RNZCUC) which includes history of the presenting complaint, past medical history, history of current medications taken and adverse drug reactions and immunisation status. The standards further require recording of relevant observations, examination findings, a diagnosis with a READ code and a management plan.'

Changes made since events

32. Dr C told HDC that he will take extra precautions with such presentations, and he now gives consideration to whether a DRE[10] may help to detect a potential mass that may represent malignancy. Dr C now ensures that he communicates and documents concerns about potential underlying and more serious conditions that would support strong advice to enrol with a GP.

33. In relation to the medical centre, Health NZ Capital, Coast and Hutt Valley told HDC that as a result of this case there has been a change of practice at the centre whereby doctors and nurse practitioners now have a lower threshold for commencing investigations in patients with chronic symptoms, particularly those without a GP and in cases where serious pathology is considered. The following changes have also been made:

- Written information has been developed to provide to patients who attend the medical centre. The information includes the importance of enrolling with a local GP, and a list of local primary health organisations. There has also been discussion with the community care teams about other strategies to support unenrolled patients to enroll with a GP.
- The medical centre's senior medical staff will review the policy on investigations, update it accordingly, and communicate this to the centre's staff.
- The medical centre's flow diagram was updated to include additional forms of communication such as email and text message for abnormal test result follow-up.

34. In response to the provisional opinion, Health NZ Capital, Coast and Hutt Valley told HDC that the blood testing policy has since been updated at the centre. The key updates include the following:

- Changes have been made to the wording to reflect that clinicians have a lower threshold to investigate if there is a serious concern about a patient's presentation;
- Follow-up on the results procedure has been changed to primarily involve text messaging or a phone call or contacting next of kin with post or email used as a last resort; and
- The blood testing policy has been updated to reiterate that routine blood screening tests are not appropriate in an urgent care setting (as opposed to stating that all non-urgent blood testing is not appropriate in urgent care).

35. A guideline has also been implemented at the medical centre, 'Unenrolled patients presenting to [the centre]', which includes clinical guidance regarding investigations for patients who are not enrolled with a GP where there is concern about significant pathology.

[10] Digital rectal examination.

36. In relation to general surgery, Health NZ Capital, Coast and Hutt Valley told HDC that the following changes have been made:

- A rectal bleeding clinic has been established, which is led by a nurse practitioner.
- All patients over 50 years, where either the GP or the triaging surgeon suspects that rectal bleeding is unlikely to be of anal origin, are now referred directly for a colonoscopy. Patients under 50 years are assessed initially in an outpatient clinic.
- Management for patients presenting to outpatient clinics with rectal bleeding has been updated. All such patients now undergo a sigmoidoscopy as part of their evaluation, either a rigid sigmoidoscopy in clinic or at the time of the operation if the former was not diagnostic, or a flexible sigmoidoscopy or colonoscopy arranged from the outpatient clinic.

Recommendations

37. Noting the improvements already made, I recommend that Health NZ Capital, Coast and Hutt Valley provide a written apology to Mr A's family for the deficiencies identified in this report relating to the care provided in 2016 and 2017. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs D.

Follow-up action

38. A copy of this report with details identifying the parties removed, except Health NZ Capital, Coast and Hutt Valley and the independent advisors on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Professor Ian Bissett:

'I am Ian Peter Bissett, a consultant general and colorectal surgeon at Auckland City Hospital. I am also a professor of the University of Auckland, Department of Surgery. I am vocationally registered with the New Zealand Medical Council and have medical qualifications of MBChB, MD, FRACS. I have also completed post fellowship subspecialty training in colorectal surgery and am a previous president of the Colorectal Surgery Society of Australia and New Zealand.

I have been asked to provide an opinion to the Commissioner on case number C22HDC02347. I have read and agree to abide by the HDC guidelines for independent advisors. I have been specifically requested to review the provided documentation and advise whether I consider the care provided to [Mr A] at [Public Hospital 1] was reasonable in the circumstances, and why.

"In particular, please comment on:

1. *Whether it would be expected for a sigmoidoscopy to be undertaken as part of [Public Hospital 1's] assessment of [Mr A] in light of his history and GP referrals. Whether the absence of this procedure represents a departure from accepted practice; and*
2. *Any other matters in this case that you consider warrant comment.*

For each question, please advise:

a. *What is the standard of care/accepted practice?*
b. *If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?*
c. *How would it be viewed by your peers?*
d. *Recommendations for improvement that may help to prevent a similar occurrence in future."*

The following documents were provided to me and specify the material available to me upon which I provide my opinion:

1. Letter of complaint dated 20 September 2022;
2. Te Whatu Ora Capital, Coast and Hutt Valley's response dated 12 December 2022; and
3. Clinical records from [Public Hospital 1] covering the period of June to November 2017.

Sequence of Events covering the time related to this advice.
[Mr A] was first referred to CCDHB by … on 20 June 2016. The presenting complaint was stated as "PR blood, PR mass, unexplained weight loss and intermittent bowel prolapse." His rectal bleeding was stated as having been occurring frequently over the previous 12 months and was at times associated with prolapse of his anal canal. The referral notes that on

examination there was "a palpable mass at the end of reach ?polyp, also blood stained stool and the prostate was small and normal".

On 4 August 2016 [Mr A] was seen in [Public Hospital 1's] general surgical clinic and the letter states "on rectal examination there were no external abnormalities and on proctoscopy he has haemorrhoids, one at the 11 o'clock position and one is quite large and prolapsing and angry." The registrar … who initially saw him called the consultant surgeon … who performed banding of his haemorrhoids. He was given pain relief and advised to return to his GP. He was informed that if his symptoms returned he should be referred back by his GP and he would be further reviewed.

[Mr A] was referred again to [Public Hospital 1] on 8 June 2017 by … with "worsening problems with haemorrhoids following banding last August ? (needing) haemorrhoidectomy." "C/O ongoing problems with haemorrhoids since appt in August 2016 — requesting referral back to hospital as per [the registrar]."

[Mr A] was seen in outpatients in [Public Hospital 2] by … General Surgical Registrar, on 28 September 2017. She noted that "He was seen a year ago in [the consultant sugeon's] clinic at which time a haemorrhoid was seen and banded. He reports that the improvement from the banding only lasted for three days and then he went back to have daily bleeding." She stated that "On examination he has a large grade 3 external haemorrhoid at the 9 o'clock position that is reducible. It is friable and bleeding." He was booked for an open haemorrhoidectomy. There is no mention of sigmoidoscopy in the letter. His haemoglobin was noted to be normal at 140 g/L.

On 8 November 2017 [another consultant surgeon], performed a Ligasure open haemorrhoidectomy. During the procedure a digital rectal examination is described and the insertion of a haemorrhoid retractor. A three pedicle haemorrhoidectomy using the Ligasure was performed. There is no mention of a sigmoidoscopy being undertaken during this procedure.

[Mr A] was discharged the following day with the plan for follow up in 6 weeks. It is stated that [Mr A] did not attend his follow up. The subsequent histology report of the haemorrhoid specimens confirmed haemorrhoids only.

According to the patient complaint a diagnosis of advanced rectal cancer was made at colonoscopy in January 2021.

Opinion

In response to the questions of the commissioner

1. Whether it would be expected for a sigmoidoscopy to be undertaken as part of [Public Hospital 1's] assessment of [Mr A] in light of his history and GP referrals. Whether the absence of this procedure represents a departure from accepted practice;

In the setting of the GP referral of 2016, where the referring GP had specifically stated that there was a possible mass at the tip of reach on digital examination, the performance of a sigmoidoscopy would be an essential part of the patient assessment even when a prolapsing haemorrhoid is identified. The possibility of a rectal mass was also included in the reason for referral/differential section of the referral document. I would consider this

to be at least a moderate departure from the expected practice and I am sure that this view would be shared by my peers.

In the setting of the second referral, more than a year after the banding with evidence that the initial management of the haemorrhoids had not given any material improvement in the patient's symptoms, I would again consider the performance of a sigmoidoscopy standard practice. This could have occurred at the outpatient assessment or during the operative procedure for the haemorrhoids. As far as I can identify from the documentation of these encounters with the patient, a sigmoidoscopy did not occur at either. This also would be a moderate departure from standard care. I have taken the opinion of another general surgical consultant, who also considered a sigmoidoscopy to be part of the expected standard of care in assessing such a patient.

2. Any other matters in this case that you consider warrant comment.

In reviewing this patient's journey I have the benefit of hindsight and this does influence the perspective that I have brought. It is certainly possible that on the first outpatient appointment the consultant who was called to do the banding was not aware of the possible rectal mass mentioned in the referral. In the second outpatient clinic assessment it is possible that the registrar who saw [Mr A] expected the sigmoidoscopy to be performed at the time of the haemorrhoidectomy, but this was not recorded in the [centre's] letter. It is also likely that the initial referral from 2016 that mentioned a possible rectal mass was not viewed during the second outpatient visit in 2017, as it would be usual practice to review the previous outpatient letter rather than the earlier referrals at this point.

The fact that the patient did not return to outpatients for review after the haemorrhoidectomy meant that the possibility for earlier identification of ongoing symptoms was lost. The identification of continued symptoms would have triggered further investigations to identify the cause. The reason for the failure of follow up is not clear but another follow up process that included telephone contact may have been more successful.

Finally, I recognise that it would be speculative to comment on whether a sigmoidoscopy performed at any of these opportunities would have changed management but it could have. Although the rectal cancer is likely to have been present at those times it could also have developed between 2017 and 2021.

I acknowledge that this has been a very distressing situation for [Mr A] and has significantly impacted his physical ability and quality of life. I also appreciate that those who cared for [Mr A] will be disturbed that this sequence of events has occurred.

Yours faithfully,

Professor Ian Bissett'

Appendix B: Independent clinical advice to Commissioner

'My full name is Stephen Leslie Adams. My qualifications are MBChB University of Auckland and Fellow of the Royal New Zealand College of Urgent Care (FRNZCUC). I have trained and practised in Urgent Care from 1991 to the present.

I have been asked to provide Independent Advice on care provided to [Mr A] on 1 May and 18 November 2020. I have been asked the following:

1. The overall management of [Mr A] at [the medical centre];
2. Whether completing a digital rectal exam would have been consistent with accepted practice when [Mr A] presented to [Dr C] at the centre on 1 May 2020;
3. Whether a physical assessment by [Dr B] would have been consistent with accepted practice on 18 November 2020;
4. The approach to investigating and managing patients with non-acute conditions at [the medical centre];

and

5. Any other matters in this case that you consider warrant comment.

I have read the HDC guidelines for Independent Advisors and agree to follow these.

I have disclosed my membership of the Royal New Zealand College of Urgent Care of which I am a member as are [Drs C and B].

With respect to the questions posed by HDC:

1. The overall management of [Mr A] at [the medical centre] concentrated on symptom control. A differential diagnosis was not carefully considered in either consultation. The RNZCUC audited standard of notes includes a differential diagnosis which was not done for either case.

2. I do not believe a digital rectal exam was indicated at the time of [Mr A's] presentation on 1 May 2020. [Mr A] was suffering from chronic diarrhoea and was very likely to have been suffering some anal inflammation as a result of this so this would have been quite uncomfortable. In addition he may have soiled himself with consequent embarrassment. A digital rectal examination is not a usual initial examination for an acute presentation with diarrhoea[1] although it would be part of a work up for change of bowel habit, usually along with a colonoscopy.

3. [Dr B] should have examined [Mr A] at his presentation on 18 November 2020 and considered differential diagnosis. It was six months and he was still having diarrhoea which had not been diagnosed or investigated. Since the previous examination by [Dr C] the findings

[1] Introduction to Clinical Emergency Medicine SV Mahadevan, Gus Carmel / 2nd edition 2012 p281

may have changed. I believe this omission would be regarded as a moderate to severe departure from standard of care.

4. It is reasonable for [a medical centre] to discourage long programmes of investigation which should be managed by the patient's General Practitioner or appropriate specialist, however it is reasonable for a [centre] to instigate early tests such as urine and faecal samples and baseline blood tests and pass the results and patient to a definitive investigator.

The Clinic's protocol for investigations has defined tests as "Urgent" or "Non-urgent" and requires patients with Urgent tests and non-enrolled patients with Non-urgent tests to stay in the [centre] until results are available. This has several difficulties (space in the waiting room, proximity to closing time, results not available the same day) and dissuades investigation by the Medical Officers. This reduces the need for the [centre] to engage in follow up but may cause the loss of an opportunity to make an early diagnosis.

Conversely the flow diagram on Page 5 advises that abnormal results should be communicated to the patient by letter, this assuming they were not kept in [the centre] until the result was obtained. In 2023, and probably 2020, text or Email was as reliable, private and certainly quicker than NZPost.

Overall I think the [centre] has a responsibility to instigate some tests based on clinical picture and therefore needs a system to ensure follow up, particularly in the context of patients with no GP.

5. In my opinion [Dr C] should have ordered stool samples in May 2020. The differential diagnosis included infection (Giardia in particular could have produced this picture), inflammatory bowel disease and malignancy. Blood in the stool, if present would have been an alert to further investigation. The RNZCUC standard training textbook,[2] states "Stool cultures may be most beneficial in … diarrhea that lasts longer than 7 days". The single diagnosis considered by [Dr C] of IBS is a diagnosis of exclusion which should only be arrived at after other possibilities have been explored.

Stephen Adams BHB, MBChB, DAFARCS, DCEM, FRNZCUC

16/05/2023'

[2] Introduction to Clinical Emergency Medicine SV Mahadevan, Gus Carmel / 2nd edition 2012

Further advice

'In 2023 I was asked to provide Independent Advice on the care provided to [Mr A] on 1 May and 18 November 2020. The following questions were put to me:

1. The overall management of [Mr A] at [the medical centre];
2. Whether completing a digital rectal exam would have been consistent with accepted practice when [Mr A] presented to [Dr C] at the centre on 1 May 2020;
3. Whether a physical assessment by [Dr B] would have been consistent with accepted practice on 18 November 2020;
4. The approach to investigating and managing patients with non-acute conditions at [the medical centre];

and

5. Any other matters in this case that you consider warrant comment.

I had read the HDC guidelines for Independent Advisors and agreed to follow these.

I had disclosed my membership of the Royal New Zealand College of Urgent Care of which I am a member as are [Drs C and B].

On 6/11/2024 I was asked to review these responses and advise if this changes anything in my initial advice.

I have read the further information supplied carefully. My initial advice was as follows and in italics are any further comments occasioned by the further responses of [Drs C and B], Te Whatu Ora, [the medical centre], Capital& Coast District Health Board and the Clinical Lead [at the medical centre]**:**

1. The overall management of [Mr A] at [the medical centre] concentrated on symptom control. A differential diagnosis was not carefully considered in either consultation. The RNZCUC audited standard of notes includes a differential diagnosis which was not done for either case. *In addition (repeating item 5 of my initial advice) the single diagnosis considered by [Dr C] of IBS is a diagnosis of exclusion which should only be arrived at after other possibilities have been explored.*

2. I do not believe a digital rectal exam was indicated at the time of [Mr A's] presentation on 1 May 2020. [Mr A] was suffering from chronic diarrhoea and was very likely to have been suffering some anal inflammation as a result of this so this would have been quite uncomfortable. In addition he may have soiled himself with consequent embarrassment. A digital rectal examination is not a usual initial examination for an acute presentation with diarrhoea[3] although it would be part of a work up for change of bowel habit, usually along

[3] Introduction to Clinical Emergency Medicine SV Mahadevan, Gus Carmel / 2nd edition 2012 p281

with a colonoscopy. *I concur with both Drs and the Clinical Lead [at the medical centre] on this matter.*

3. [Dr B] should have examined [Mr A] at his presentation on 18 November 2020 and considered differential diagnoses. It was six months and he was still having diarrhoea which had not been diagnosed or investigated. Since the previous examination by [Dr C] the findings may have changed. I believe this omission would be regarded as a moderate to severe departure from standard of care. *I note* [*Dr B] agrees that relevant examination of a patient with symptoms is usual. Mutual agreement as to not going further than symptomatic treatment is not documented.*

4. It is reasonable for [a medical centre] to discourage long programmes of investigation which should be managed by the patient's General Practitioner or appropriate specialist, however it is reasonable for a [centre] to instigate early tests such as urine and faecal samples and baseline blood tests and pass the results and patient to a definitive investigator.

The [centre's] protocol for investigations has defined tests as "Urgent" or "Non-urgent" and requires patients with Urgent tests and non-enrolled patients with Non-urgent tests to stay in the [centre] until results are available. This has several difficulties (space in the waiting room, proximity to closing time, results not available the same day) and dissuades investigation by the Medical Officers. This reduces the need for the [centre] to engage in follow up but may cause the loss of an opportunity to make an early diagnosis.

Conversely the flow diagram on Page 5 advises that abnormal results should be communicated to the patient by letter, this assuming they were not kept in [the centre] until the result was obtained. In 2023, and probably 2020, text or Email was as reliable, private and certainly quicker than NZPost.

Overall I think the [centre] has a responsibility to instigate some tests based on clinical picture and therefore needs a system to ensure follow up, particularly in the context of patients with no GP. *I note [the medical centre] is at least partly in agreement with these recommendations and has changed its protocols.*

5. In my opinion [Dr C] should have ordered stool samples in May 2020. The differential diagnosis included infection (Giardia in particular could have produced this picture), inflammatory bowel disease and malignancy. Blood in the stool, if present would have been an alert to further investigation. The RNZCUC standard training textbook,[4] states "Stool cultures may be most beneficial in … diarrhea that lasts longer than 7 days". The single diagnosis considered by [Dr C] of IBS is a diagnosis of exclusion which should only be arrived at after other possibilities have been explored. *My opinion on this is unchanged. While this is not a test for malignancy and it may not have contributed to the outcome it is a basic step in the diagnostic process for diarrhoea which was how [Mr A] presented to [Dr C] and so in my opinion omission of this constituted a departure from standard of care, regardless of the final*

[4] Introduction to Clinical Emergency Medicine SV Mahadevan, Gus Carmel / 2nd edition 2012

outcome. I have not suggested Faecal Occult Blood testing for this presentation, my comment as to the presence of blood refers to microscopic examination of faeces.

In answering this question I am not considering the long term outcome in my weighting of the departure from standards, just the departure from usual Urgent Care standards.

In itself I would identify the departure — failure to exclude diagnoses other than Irritable Bowel Syndrome (which in itself is a diagnosis by exclusion) moderate. However as he was working in a [medical centre] that discouraged laboratory investigation and if he had clearly stated the need for such further investigation by a GP this might be downgraded.

Likewise the failure to order stool samples for microscopy and culture — the investigation that could reveal an infectious and easily treatable cause for the symptoms would be considered moderate but in the light of the [centre's] policy against investigation might also be downgraded.

It is however difficult to know how much of an influence the [centre's] policy was on [Dr C's] actions or how easily he could have over-ridden that policy based on the clinical picture in this case. So I'm afraid I can't be more precise as to whether these were moderate or mild departures from standards.

Stephen Adams BHB, MBChB, DAFARCS, DCEM, FRNZCUC

References:

Introduction to Clinical Emergency Medicine SV Mahadevan, Gus Carmel / 2nd edition 2012 p281'

Appendix C: [The medical centre] blood test procedure and process

Document facilitator: Clinical Leader, [redacted]
Senior document owner: Clinical Leader [redacted]
Document number: [redacted] **Issue Date:** 11 February 2020 **Review Date:** 11 February 2023

Type: **Procedure**

Name: **Blood test procedure and process for checking and tracking of Radiology and Laboratory results and staff tasks at** [redacted]

Procedure Purpose:
There is presently no requirement for laboratory services to be part of the diagnostic facilities of [redacted] (Urgent Care Standards 2015). [redacted] is sited within [redacted] and as such has access to limited laboratory facilities during business hours only.

[redacted] Laboratory is open [redacted] On site they do FBC, CRP, U&E, BS, Ca/PO4, LFT, amylase and INR. Notably they do not do d-dimer or Trop T which, like all out of hours blood tests, are done at [redacted] Hospital. Outside of office hours no laboratory investigations are able to be done at [redacted]

Only request laboratory or radiological tests that are relevant for immediate management. There are occasions when it is in the patient's best interest to have a blood test requested at [redacted] These are:

1) When the results of an urgent blood test that can be done at [redacted] laboratory will allow for safe discharge of a patient home.
2) A non-urgent blood test but still desirable given the patient's presentation and likelihood of early GP follow-up.
3) The patient is going to be transferred to [redacted] & it is appropriate to do blood cultures prior to initiation of IV antibiotics. Note that there is NO agreement with ED to request acute blood tests prior to cannulation or transfer to [redacted] for acute coronary presentations.

The purpose of this procedure is to ensure that when laboratory investigations are requested there is a plan to allow for the safe follow up of the patient and results and each person is aware of their responsibilities.

Scope
This procedure relates to Doctors and Nurses in [redacted] as well as Duty Nurse Managers.

Names (except Health NZ Capital, Coast and Hutt Valley and the independent advisors on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Document facilitator: Clinical Leader, [redacted]
Senior document owner: Clinical Leader [redacted]
Document number: [redacted] **Issue Date**: 11 February 2020 **Review Date**: 11 February 2023

Procedure

1. Taking of blood sample

During business hours instruct patients to use the phlebotomy service available in the Outpatient Department in [redacted]

After hours all nurses at [redacted] can take blood. Do not let patients take lab request forms home or to a community laboratory. In the past this practice caused many tests not being done and the onus on [redacted] tracking to follow up on tests not done.

In the situation where the patient is being transferred to [redacted] by ambulance and blood cultures are required prior to IV antibiotics; medical staff should fill in the lab requesting form; and the sample and form should accompany the patient in the ambulance to [redacted]

Please note [redacted] do not take blood as requested by [redacted] either take the blood themselves or contract this out to [redacted] after-hours. If there is any doubt, the patient should contact [redacted] themselves.

2. Sending of blood to the laboratory

For procedures specifically related to Trop T Bloods please see [redacted] internal policy (attached).

During business hours an orderly can be paged to take the blood to the laboratory. Please note that the laboratory closes at [redacted] so if sending a sample after [redacted] or [redacted] you must ring the laboratory and ensure the sample will be able to be processed prior to end of business day.

Urgent after-hours blood samples are sent via taxi arranged through the duty manager. The turnaround time for receiving results is approximately a 3 hour. Blood testing after 16:30hrs should be restricted to situations where the result will make an immediate difference to management. Please keep such patients on the premises until the result is available as historically it has been difficult contacting patients once they have left [redacted].

3. Receipt of Results

a) Urgent results will be faxed to [redacted].

It is the responsibility of reception staff to then put faxed results in a red folder and in front of the queue of files for the duty doctor to action next.

b) Process for checking routine laboratory and X-ray results (Inbox results)

It is the responsibility of the doctor starting at **8 am (Mon-Sun)** to check Inbox results and Staff Tasks. A clinic nurse may remind the doctor of this duty. This paper explains the procedure to be followed.

In Box Results:

1) In MedTech, click on "**Provider In Box**" on the toolbar (or click on Module, then In Box, then Provider In Box)
2) Click on rainbow icon (Active only)

Names (except Health NZ Capital, Coast and Hutt Valley and the independent advisors on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Document facilitator: Clinical Leader, [redacted]
Senior document owner: Clinical Leader [redacted]
Document number: [redacted] **Issue Date**: 11 February 2020 **Review Date**: 11 February 2023

3) In the "**Attention box**", type in "**All**" (or use the drop down arrow to select "**All**")

4) Click "**OK**". All patient results will then appear

5) Double click on the result to bring up individual results

If a result is normal (or needs no further clinical intervention), record this in "**Comments**", then press "**file**". Some results has a staff task attached to the results and a "**Complete Staff Tasks**" box will pop up. Tick the box and then click on "**Complete**"

If result is abnormal (or needs further clinical intervention), click on the result, then click on the red/blue arrow to make the patient active and ensure patient has been managed appropriately. If patient needs further clinical intervention or notification, then refer to "**Process for abnormal results**" (see below). Record findings in **comment** section and once action has been taken, press "**file**". If "**Complete Staff Tasks**" box pops up, tick the box and then click on **"Complete".** Please complete this step to ensure that the **"Incomplete Tasks"** list does not include those results that have in fact been actioned.

X-rays, ultrasound and hard copy reports:
Receptionists place hard copy reports in the "**Reports for Review**" tray to right as you walk into receptions (in the same area where GPs sign in for shifts). Review all the reports. All normal results should be signed and dated and placed in the "**Reports for Filing**" tray. Abnormal reports should be checked against the patient's records to ensure appropriate action has been taken. Contact patients with missed fractures or abnormal results for appropriate follow-up. Sign and date results and place in the "**Reports for Filing**" tray.

c) Completing staff tasks

"Staff Tasks" are generated for each investigation request (laboratory and radiology) and for referral letters. This is to ensure appropriate action has been taking for significant clinical events. It needs to be checked daily.

To check "**Staff Tasks**", click on lightbulb on the MedTech toolbar, then click on rainbow icon and under "**Staff Member**" type in "**All**" (or use the drop down arrow to select "**All**") and then click "**OK**".

A list of Staff Tasks will appear in red and in black. All the tasks that appear in red AND has an entry in the "**Patient**" field, requires action. Do NOT action task with an empty "Patient" field - these are individual doctors' personal tasks. Each request needs to be checked that there has been a result received and this result has been managed. If there has been no result received, clinical notes should be reviewed. If receipt of the result is deemed to be urgent, then attempts should be made to contact the patient. If not urgent a letter should be faxed to the patient's GP requesting follow up. Refer to "**Process for abnormal results and incomplete tasks**" (see below). Click "**Complete**" and then "**OK**" once you have completed the task.

Document facilitator: Clinical Leader, [redacted]
Senior document owner: Clinical Leader [redacted]
Document number: [redacted] **Issue Date:** 11 February 2020 **Review Date:** 11 February 2023

d) GP requested Laboratory Results

The management of clinical investigations is addressed in Chapter 7 of "Cole's Medical Practice in New Zealand" (https://www.mcnz.org.nz/assets/standards/da3a9995b9/Coles-Medical-Practice-in-New-Zealand.pdf). BPAC has also published a discussion article on "Taking responsibility of test results" https://bpac.org.nz/BT/2014/August/testresults.aspx) and states "The responsibility for developing an effective method of managing test results lies with both the individual clinician and with the professional community within which they practice". Also note the RNZCGP discussion on this topic (https://www.rnzcgp.org.nz/gpdocs/New-website/Advocacy/PB6-2016-Apr-Managing-patient-test-results.pdf).

[redacted] works in partnership with [redacted] to cover GP patients' afterhours. However, given the principles from the resources mentioned above, GPs are ultimately responsible for the management of test results on tests they have ordered and it seems reasonable for the ordering GP who best knows their patient's medical history, to be make their contact details available to [redacted]. As per agreement, [redacted] will in the first instance attempt to contact the ordering GP for critical tests (during business hours and after hours).

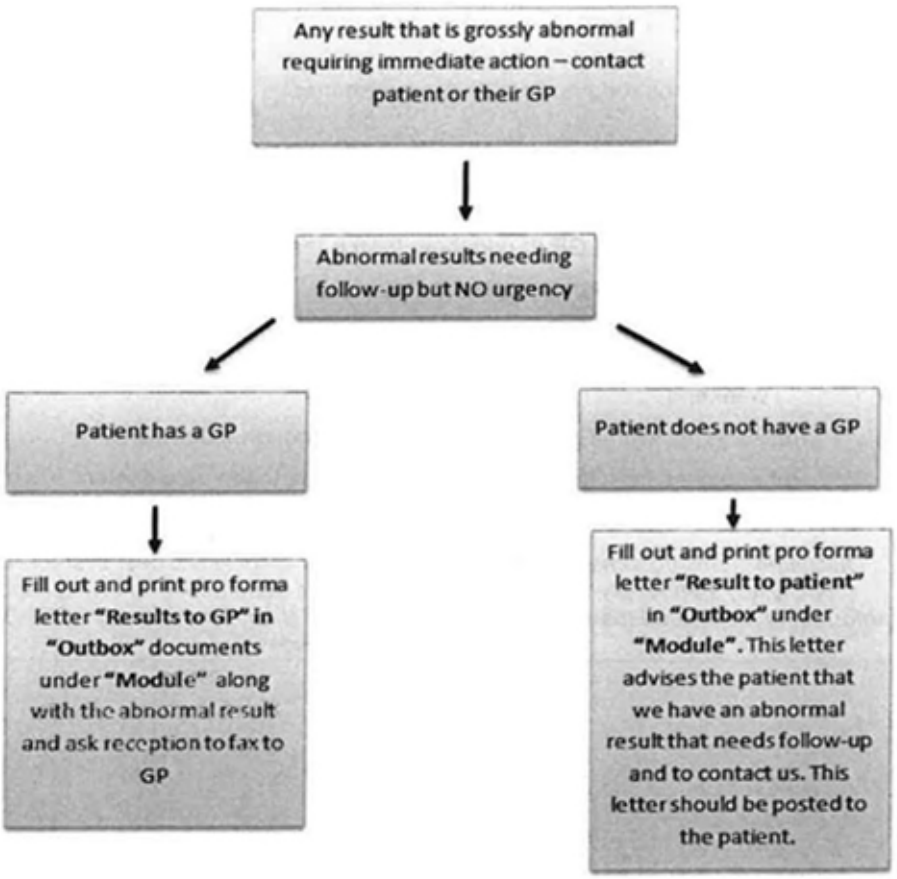
Should a GP suspect a critical result coming through afterhours and know that they will be unavailable, then the GP should hand the case over to [redacted] (via telephone or faxed letter with notes). In the rare occasion when the GP is not contactable, [redacted] will contact an on duty doctor at [redacted]. [redacted] will then attempt to contact such a patient with a critical results to arrange follow-up care provided that:

- [redacted] has made reasonable efforts to speak to the ordering GP
- The result is genuinely critical
- There are adequate contact details for the patient (i.e. obtainable from Concerta, Medtech32 or [redacted] database)
- [redacted] contacts the GP urgently the next day, and does not regard [redacted] as accepting final responsibility for the test results

If a patient with a critical test cannot be contacted via phone, then [redacted] will request [redacted] ambulance paramedic or NZ police officer to visit the patient and ensure safe care can be provided.

Document facilitator: Clinical Leader, [redacted]
Senior document owner: Clinical Leader [redacted]
Document number: [redacted] **Issue Date**: 11 February 2020 **Review Date**: 11 February 2023

Process for abnormal result follow up - [Outbox refers to Medtech system]



Laboratory result enquiries
All laboratory results ordered at [redacted] are sent electronically to the patients' regular GP. Significant abnormalities are sent by fax. It is desirable that patients direct enquiries to their regular surgeries to ensure any follow up management is undertaken by their own doctor. To this end, staff are asked to follow the following procedures.

Doctors

For urgent investigations, keep the patients until the result is known.

For non-urgent investigation (which should be minimal)

- If patient is enrolled with a GP advise them to contact their regular doctor for results.
- If the patient is not enrolled with a local GP they must remain in [redacted] for the results.

Blood test procedure and process for checking off Radiology and Laboratory results at [redacted]
CapitalDoc ID: 1.101471 Page 5 of 6
Regard printed versions of this document as out of date – The Capital Document is the most current version
Capital & Coast District Health Board

Document facilitator: Clinical Leader, [redacted]
Senior document owner: Clinical Leader [redacted]
Document number: [redacted] **Issue Date**: 11 February 2020 **Review Date**: 11 February 2023

Nurses

Only give out results to the patient where a patient has no local GP, or where a potentially urgent result is needed after hours

Where patients claim their GP told them to ring us, take their details & ring the GP directly

Give results on request to GP's & practise nurses

Receptionists

When the public ring about laboratory results, determine from the system whether they have a GP:

- Advise those with a GP to ring them for the result
- Only put calls through to nurse where:
  - Callers have no GP
  - The caller claims the problem is urgent and GP surgeries are not open (e.g. the weekend)

Put enquiries from GP's or practise nurses through to the nurse

Put enquiries from the [redacted] through to the duty doctor

Disclaimer: This document has been developed by Capital & Coast District Health Board (CCDHB) specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and CCDHB assumes no responsibility whatsoever.