Medical Centre
General Practitioner, Dr B

A Report by the
Health and Disability Commissioner

(Case 20HDC00966)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man over a period of five years by his general practitioner (GP) and a medical centre, from January 2014 until the man was diagnosed with stage four kidney failure in November 2019.

2. The man's wife complained that the GP failed to identify the man's kidney disease as far back as 2015 and refer him to a kidney specialist. The man's wife also raised concerns that throughout this period the GP continued to prescribe non-steroidal anti-inflammatory drugs (NSAIDs), which can be harmful to the kidneys.

Findings

3. The Commissioner considered that the GP did not advise the man of his deteriorating renal function in a timely manner, or investigate his impaired kidney function adequately and implement a robust ongoing management plan. The Commissioner also considered that the GP failed to convey to the man effectively the risk of ongoing use of NSAID medication in the context of impaired renal function, and did not document attempts to follow up on overdue test results adequately, or convey that his intention to refer the man to a specialist was dependent on the tests being undertaken. The Commissioner found that collectively these deficiencies represented a failure to provide services with reasonable care and skill. Accordingly, the Commissioner found the GP in breach of Right 4(1) of the Code.

4. The Commissioner also considered that in not being adequately informed of his deteriorating renal function test results in a timely manner, and about the risk of ongoing use of NSAID medication in the context of impaired renal function, the man was not provided with information that a reasonable consumer in his circumstances would expect to receive. Accordingly, the Commissioner found that the GP breached Right 6(1) of the Code.

5. The Commissioner made adverse comment about the medical centre's management of the complaint.

Recommendations

6. The Commissioner recommended that the GP provide a written apology to the man and his family, and conduct an audit to ensure that clinical documentation is of an appropriate standard according to the Medical Council of New Zealand practice guidelines. The Commissioner also recommended that the Medical Council of New Zealand consider whether a review of the GP's competence is warranted.

7. The Commissioner recommended that the medical centre provide a written apology to the man and his family, conduct a further audit to ensure that patients with an eGFR below 60 are classified appropriately, and use an anonymised version of this report as the basis for communication and complaints management training for staff.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her husband, Mr A, by a medical centre and Dr B. Specifically, Mrs A complained about the diagnosis and management of Mr A's kidney disease. The following issues were identified for investigation:

- *Whether the medical centre provided Mr A with an appropriate standard of care between 21 July 2015 and 18 April 2020 (inclusive).*
- *Whether Dr B provided Mr A with an appropriate standard of care between 21 July 2015 and 18 April 2020 (inclusive).*

9. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Complainant/consumer's wife
Medical centre	Group provider/general practice clinic
Dr B	Individual provider/general practitioner (GP)

10. Further information was received from Dr C, the Chief Medical Advisor to the owner of the medical centre, and the district health board (DHB).

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

Information gathered during investigation

Introduction

12. Dr B was Mr A's GP from 7 January 2014. In November 2019 Mr A was diagnosed with stage four kidney failure. This complaint relates to the diagnosis and management of Mr A's kidney disease. The care provided to Mr A by Dr B spans a period of five years, with only the consultations relevant to the scope of the investigation being discussed in this report.

Visits to GP

21 July 2015

13. On 21 July 2015, Mr A (aged in his thirties) presented to Dr B for an annual check-up. Mr A told HDC that he would visit Dr B yearly. Dr B advised that on this occasion, Mr A requested a prescription for Brufen Retard (Brufen) tablets[1] for chronic back pain. Brufen belongs to a group of medicines called non-steroidal anti-inflammatories (NSAIDs) and is used as a painkiller. NSAIDs work by blocking prostaglandins (natural bodily chemicals that normally

[1] A previous prescription had been provided by Dr B on 7 January 2014.

dilate blood vessels). NSAIDS may lead to decreased blood flow to the kidneys, which can cause kidney injury.

14. Dr B told HDC that Mr A's request prompted him to ask about Mr A's use of NSAIDs. Dr B said that Mr A told him that his previous GP had been prescribing Voltaren (another NSAID medication), so he suggested that Mr A undergo kidney function tests, as "long term usage of this class of medication can cause a reduction in kidney function". This conversation was not recorded in the clinical notes. Dr B prescribed Mr A with Brufen[2] on this visit.

15. Renal function blood tests include a measure of the estimated glomerular filtration rate (eGFR) and creatinine level, which measure the kidneys' ability to filter toxins or waste from the blood. The results of Mr A's renal function test, received on 23 July 2015, showed that he had an eGFR of 60ml/min/1.73(2) (below normal range)[3] and a creatinine level of 134µmol/L (normal range 50–110). These abnormal results were documented by Dr B as "eGFR 60 — [aged in thirties]". However, there is no documentation that Mr A was informed of his test results.

5 November 2015

16. Mr A returned to Dr B on 5 November 2015 for left ankle pain. Dr B documented: "Long chat on Brufen for inflammation … He has Brufen at home — happy to rescript anytime." The details of the discussion about Brufen are not documented. Dr B said that he did not prescribe NSAIDs on this visit, and he discussed with Mr A the results of the previous renal function tests. However, this discussion was not documented, and no further renal function tests were ordered at this visit.

19 May 2016

17. Mr A presented to Dr B asking to have his cholesterol checked as he had a family history of heart disease. Dr B measured Mr A's blood pressure (BP), which was normal,[4] and ordered lipid tests[5] and a recheck of Mr A's renal function. The results of this renal function test, received on 1 June 2016, remained similar[6] to the previous test result (stable but impaired). Dr B told HDC: "This would be consistent with previous kidney damage, possibly an acute kidney injury (AKI)." However, there is no documented discussion of the previous renal function test results (received on 23 July 2015) or of the results received on 1 June 2016. There was also no discussion about the risks of continuous use of NSAIDs.

21 June 2016

18. Mr A visited Dr B again to discuss the initiation of statins (medication used to reduce levels of cholesterol in the blood) due to his family history. There is no documented discussion regarding any previous test results of Mr A's renal function on this visit. No renal function

[2] 800mg sustained release tablets x 60.
[3] The GFR range for a young male adult is 87–167. From age 30, values fall by approximately 1 mL/min/year.
[4] 120/78mmHg.
[5] A panel of blood tests used to find abnormalities in lipids, such as cholesterol and triglycerides, which can determine approximate risks for cardiovascular disease.
[6] These results showed an eGFR of 61 and a creatinine level of 131 (abnormal).

tests were ordered on this date. There was also no discussion about the risks of continuous use of NSAIDs.

11 January 2017

19. Mr A presented to Dr B seeking a referral to an acupuncturist for shoulder and neck pain. Dr B had prescribed Norflex (a muscle relaxant used for muscle pain) on 12 December 2016. On this visit, Dr B provided Mr A with an acupuncturist referral and a prescription for Brufen.[7] Dr B recorded in the clinical notes: "[R]ecomment [sic] brufen retard as an anti-inflammatory. Open door for review." No further renal tests were ordered on this visit, nor was there any discussion about Mr A's previous test results or the risks of continuous use of NSAIDs.

15 February 2017

20. Mr A presented to Dr B complaining of pain in his right ankle. On this occasion, Mr A questioned whether the pain could be due to gout, as he had suffered from gout previously. Gout is a form of arthritis caused when too much uric acid crystallises and deposits in the joints.

21. Dr B said that Mr A told him that he had been taking Ponstan (mefenamic acid — an NSAID) for the treatment of gout, but that he wanted another prescription for Brufen. Dr B documented: "Stop Brufen SR, [s]tart ibuprofen 200mg with cautionary guidance. Uric acid [test],[8] then consider Allopurinol.[9] Repeat Lipids."

22. Subsequently, Dr B ordered further renal function and blood lipid tests and documented that he had ordered a renal ultrasound. However, he did not in fact order an ultrasound at this time. The results of the tests showed an eGFR of 49 (abnormal), creatinine of 156, and an elevated uric acid level of 0.58. The uric acid result was consistent with a diagnosis of gout. There is no documentation recording that Dr B informed Mr A of these test results at this time.

23. Dr B prescribed allopurinol[10] on 24 February for the treatment of gout. He also prescribed ibuprofen (another NSAID medication).[11] Dr B told HDC that he suggested that Mr A use short-acting ibuprofen (Nurofen) "for the shortest time". However, there was no substantive discussion about the risks of continuous use of NSAIDs.

14 March 2017

24. Mr A returned to Dr B as he had been experiencing nausea with the use of allopurinol. Dr B changed Mr A's gout medication to probenecid. Mr A had continued to take Brufen. Dr B documented the following:

[7] 800mg x 60 tablets.
[8] A test to see how much uric acid is in the urine, to understand whether the body is breaking down cells too quickly or not removing the uric acid quickly enough.
[9] A medication used to decrease high blood uric acid levels to prevent gout.
[10] 100mg (once daily).
[11] 200mg tabs x 200.

> "In today — he felt nausea with the Allopurinol. High uric acid and wants an alternative [preventative medicine]. He had also stopped the statin. On Brufen for pars defect — intermittent usage. Note eGFR … Discussed eGFR — he has had no acute event. Cautioned to limit NSAID usage given eGFR — repeat today, and I will seek an ultrasound."

25. Dr B said that he discussed Mr A's renal function, including his past test results and the "importance of not taking medications from the NSAID family". Dr B stated that he suggested that Mr A undergo an ultrasound to ensure that his kidneys were structurally normal and that there were no growths or obstructing lesions in the kidneys. Dr B said that Mr A elected to have the ultrasound done privately, and that he posted the referral for the ultrasound on the same day.

26. At this visit, Dr B also provided a form for repeat blood tests, which were completed in May 2017.[12] However, there is no record of the test results being discussed with Mr A until 17 July 2017, when it is documented that Dr B "discussed renal function".

10 April 2017

27. Mr A again presented to Dr B with ongoing pain in his right foot. Dr B provided Mr A with another form for repeat renal function blood tests. The blood tests were completed on 18 May 2017[13] and showed that Mr A's renal function remained impaired but had improved slightly, showing an eGFR of 52 and a creatinine level of 149. Dr B made a further referral for a renal ultrasound, and prescribed Mr A with ibuprofen,[14] documenting: "Paracetamol [four times a day], and ibuprofen only for breakthrough pain." However, there was no substantive discussion about the risks of continuous use of NSAIDs.

28. The renal ultrasound results (reported on 23 April 2017) showed a small 6mm left renal cyst but were otherwise normal. Dr B noted these results in the clinical notes but did not discuss the results with Mr A at the time.

17 July 2017

29. Mr A saw Dr B after straining his back. Dr B said that Mr A's renal function was again discussed, and the need to avoid NSAIDs was highlighted. Dr B documented: "He has NSAID at home … Discussed renal function, and [ultrasound] findings." Dr B prescribed Mr A non-NSAID medications.

1 December 2017

30. Mr A presented to Dr B complaining of pain in his right ankle. Dr B prescribed Mr A with non-NSAID medication[15] for the treatment of gout, and documented:

[12] Dr B ordered tests on both 14 March 2017 and 10 April 2017. Test results were next recorded on 18 May 2017. It is unclear whether those tests are attributable to the order of 14 March 2017 or the order of 10 April 2017.
[13] See footnote 12.
[14] 200mg x 200.
[15] Prednisone 20mg x 10.

> "A: Flare of gout = on Probenecid — intolerant of Allopurinol. P: Prednisone, bland diet for a few days, Open door for review anytime. Brief discussion on eGFR stable, and [ultrasound] kidneys."

31. Dr B said that on this visit, "[he] stressed the need to avoid NSAID medications".

8 February 2018–17 July 2018

32. On 8 February 2018, Mr A rang the medical centre and spoke to the practice nurse and requested a repeat script for his gout medication (probenecid and atorvastatin, both non-NSAIDs). The practice nurse asked Dr B if Mr A required another renal function and lipids test. Dr B said that he did, and Mr A underwent the blood tests on 12 March 2018. The results showed a modest deterioration[16] since the last tests done in May 2017.

33. Dr B annotated the result: "Send for advice from physicians." However, Dr B said that he elected to withhold making the referral until the tests were repeated. Dr B did not discuss his intention to refer Mr A to a specialist, or that he planned to do so on receipt of further blood test results. The renal function test results of 12 March 2018 were not communicated to Mr A when he returned to see Dr B on 17 July 2018.

34. Mr A presented to Dr B on 17 July 2018 with an upper respiratory tract infection. At this visit, Dr B discussed the results of the ultrasound scan of 10 April 2017. The electronic record shows that Dr B ordered and provided Mr A with a form for repeat renal function tests. Dr B said that he also ordered a urine albumin: creatinine ratio (ACR) test. (This test measures the amount of the protein albumin in the urine, and can help to identify kidney disease.) However, the electronic clinical record does not reflect that this test was ordered. Dr B explained to HDC that at the time, he would handwrite "ACR" on the laboratory form rather than record it electronically.

35. Dr B documented: "Discussed renal [ultrasound]. Repeat bloods." However, subsequently the blood and ACR tests ordered on 17 July were not completed by Mr A. Dr B told HDC: "Tracking mechanisms were in place to ensure that prompt referral would have taken place had the requested blood and urine tests been done …"

16 October 2019

36. Mr A presented to Dr B for a musculoskeletal concern. Dr B said that he suggested to Mr A that he should avoid NSAID medications, and he instead prescribed paracetamol. Dr B documented: "Paracetamol given past eGFR." Dr B said that he discussed Mr A's previous renal function test results in the context of the need to avoid NSAIDs. However, there is no documentation of this. Dr B provided Mr A with another form for a renal function test, but again Mr A did not complete the test.

37. Mr A told HDC that he recalls an appointment between 16 October and 18 November where he presented to Dr B with headaches and vomiting and was prescribed with paracetamol.

[16] eGFR 45 and creatinine 167.

Dr B said that he has no recollection of a consultation during this period, and there is no record in the clinical notes or the appointment record.

18 November 2019

38. On this visit, Mr A was concerned about headaches, his eGFR, and his blood pressure. Mrs A told HDC that by this point she was becoming increasingly concerned about her husband's health, and he continued to return from consultations with no further investigations into his symptoms, so she attended the 18 November appointment with him. Dr B told HDC that this was a long consultation, during which he conducted extensive examinations in relation to Mr A's cardiovascular and neurological systems, and commenced a management plan that included a referral to a physician, a referral for a CT scan, 24-hour blood pressure monitoring, and commencement of a blood pressure medication.[17] Dr B recommended that Mr A undergo urgent blood tests.

39. Conversely, Mrs A told HDC that she became upset and pushed Dr B to investigate her husband's symptoms further by way of blood tests. She said that she suggested to Dr B that her husband might have a brain tumour, but Dr B laughed at this. Mrs A also said that on this occasion, Dr B told her to "go to the supermarket and get [Nurofen]" for Mr A's headaches.

40. Dr B told HDC that he was respectful of Mrs A's suggestion that her husband might have a brain tumour, because "irrespective of how unlikely they may be, [all possible diagnoses] remain a possibility until they are proven or disproven by appropriate tests". Dr B said that he has never, and would never, laugh at a patient. Further, Dr B told HDC that Nurofen is contraindicated in patients with chronic kidney disease (which Mr A was known to have at the beginning of the consultation on 18 November 2019) and, as such, he did not encourage the purchase of Nurofen from the supermarket. However, he did say that he was respectful of "[Mrs A's] right to purchase Nurofen from a retail provider of her choice if she wished to do so".

41. Blood test results reported later the same day showed markedly reduced renal function, with an eGFR of 17 and creatinine of 372. Dr B documented the following:

> "In today with his wife — to discuss headaches, eGFR and his BP. **He tells me that he has taken a lot of Brufen in the past** … P: CT head, Refer physicians, and to Dr … in private. Start [medication used to treat high blood pressure and kidney disease[18]], blood and repeat eGFR in a week. Holter[19] for BP … Note: Creatinine is elevated, and eGFR has dropped. I have discussed the case with [a physician at the hospital] and she has agreed to admit him for observations … I phoned [Mr A]." (Emphasis in original.)

42. Mr A was sent to the Emergency Department at the public hospital for further investigations and treatment. Unfortunately, he was diagnosed with Stage 4 kidney disease. A person with

[17] Quinapril.

[18] An angiotensin converting enzyme (ACE) medication.

[19] A Holter monitor is a type of portable electrocardiogram (ECG) that records the electrical activity of the heart continuously over 24 hours or longer.

Stage 4 kidney disease has advanced kidney damage, and is likely to need dialysis or a kidney transplant in the near future.

43. A review conducted by the nephrology registrar on 16 December 2019 stated: "[Mr A] has had progressive renal impairment for five years. [Mr A] was aware [h]is kidney function was abnormal but didn't appreciate the significance of this."

Subsequent events — Mrs A's complaint to medical centre

44. On 20 February 2020, Mrs A hand delivered (on behalf of Mr A) a letter of complaint to the medical centre. The complaint stated:

> "I am just wanting an explanation of your reasoning for not referring me to a kidney specialist/nephrologist when in 2015 my [e]GFR was 59 and in 2017 it was 49 to Nov 2019 at 17."

45. The practice manager told HDC that Dr B read the letter and supplied it to her on the same date, at which stage it was treated as a request for information rather than a complaint.

46. On 20 March, Mrs A delivered a follow-up letter asking why the medical centre had not responded to the complaint. The medical centre emailed the family on the same day acknowledging the correspondence and stating that the complaint letter would be responded to the following week.

47. On 7 April 2020 and 29 April 2020, the medical centre sent two emails to the family advising of delays in responding to the complaint.[20] However, it appears that these emails were not received by Mrs A. The medical centre also said that telephone conversations were held with Mrs A and Mr A's father, but details of the conversations were not documented.

48. On 18 April 2020, a draft letter of response from Dr B was supplied to the medical centre practice manager, and on 6 May 2020 Mrs A sent a follow-up email to the practice manager advising that she had still not heard back regarding her complaint. This email was responded to on the same day, and advised Mrs A that she had been sent two emails on 7 and 29 April explaining the circumstances around the delay.

49. The medical centre told HDC that Dr B's response was not provided to the family because the medical centre had already commenced an independent clinical review, and the letter was to be provided to the family once the review had been completed. Subsequently, the clinical review took longer than expected, and the HDC complaint was received before the review had been completed. The medical centre told HDC:

> "We understand the importance of complaints and communication during this process, and in this instance due to added pressures at the time, this did not reach the expectations of the practice. We are truly sorry for the unforeseen delays."

[20] Owing to the COVID-19 pandemic and doctor illness. The medical centre told HDC that during the COVID-19 lockdown, the practice split into two teams to mitigate the risk of COVID-19 spread, which increased the workload within the practice.

Further information

Mr and Mrs A

50. Mr A told HDC that Dr B had told him previously that he had "kidneys of a sixty year old", but that he was offered no further advice and was told that it would be monitored. Mr A stated that he does not recall being made aware of the risks of continued NSAID usage, and said that he had been taking NSAID medications for years for ongoing back pain without being aware of potential side-effects. He also told HDC that he does not recall receiving any reminders or follow-ups from Dr B regarding the need to complete the ordered blood tests. Mrs A told HDC:

> "[Mr A] is quite proactive with his health and if he ever thought there was something wrong he would have looked into it ... [He] would still go to the doctor on[c]e a year for [blood tests] and a check up …"

51. Finally, Mrs A told HDC:

> "The complaint is not going to change the outcome for my husband [and] he will still be in end stage kidney disease bu[t] if we [had] found out [five] years ago it would have not come as such a shock [and] we could have made lifestyle changes to slow the progression of the disease … and most of all we could have appreciate[d] life and our young family … while [Mr A] was well enough to do so."

Dr B

52. Dr B said that this complaint has made him hyper-vigilant and risk-averse to avoid a similar situation happening in the future. Dr B stated:

> "I am deeply regretful that harm has come to [Mr A], and that our clinical relationship suffered because of this harm. If it was within my power to remedy this for [Mr A], I surely would."

<u>Tracking and follow-up of tests</u>

53. Dr B told HDC that at the time of these events, he used a number of tracking modalities to ensure that tests and further investigations were undertaken. Dr B stated:

> "I use a number of tracking modalities to ensure that tests and investigations are performed, and to follow up on results of tests and investigations. In many cases, I follow up on requests if tests or investigations have not been done within a reasonable timeframe. I kept track of [Mr A's] non-compliance with blood and urine test requests, and raised these with him, eventually I felt that I had to respect his autonomous right to not consent to having the blood and urine tests done despite his being informed of the reasons for, and advisability of, having them done promptly."

54. However, Dr B acknowledged that he did not use formal tracking processes in Medtech32 (electronic patient management software) at the time.

55. Dr B told HDC that he recalls following up with Mr A on his overdue test results on numerous occasions and emphasising the importance of completing the tests, but acknowledges that

his attempts to contact Mr A, along with notes of Mr A's response, were not documented. Dr B said that he considered that the response from Mr A "was not to refuse but to indicate that the tests would be attended to when commitments allowed".

Communication of test results and caution on use of NSAIDs

56. Dr B told HDC that although not always documented in his notes, he is clear that he discussed Mr A's renal function results with him on most, if not all, of the occasions on which he saw Mr A. Dr B said that he provided ongoing encouragement to stop the use of NSAID medications, and that he wanted to impart the message strongly without causing Mr A to lose confidence in him or feel the need not to disclose what over-the-counter medications he was taking.

57. Dr B told HDC:

> "I have always ascribed to the dictum that medications such as [NSAIDs] … should be used at the lowest dosage and for the shortest time. I believe that my record of prescribing for Mr A attests to this."

58. Dr B said that it is his belief that the cause of Mr A's declining kidney function was his "self-reported" usage of NSAID medications, and that he was clear with Mr A on this fact. Dr B told HDC:

> "My discussions with him, including my repeated discussions on the topic of nephrotoxic medications and my subsequent refusal to prescribe NSAID medications, along with the repeated testing … all clearly communicated that his kidney function was impaired."

59. Dr B stated that on reflection, he should have initiated the termination of the clinical relationship with Mr A on the basis of non-compliance. However, Dr B said that he felt that it was his professional duty to continue to encourage Mr A to reduce his use of NSAIDs and undergo blood and urine tests, "rather than passing that task onto one of [his] colleagues".

Medical centre

60. The medical centre acknowledges that for a while, there were not rigorous enough processes in place to ensure that critical test results were always followed up, but it has now improved its processes to keep up with the growing practice.

Policies, processes, and guidelines

61. The medical centre provided HDC with its relevant policies in place at the time of these events, and guidelines that were available for clinical staff. These included:

- Best Practice Advocacy Centre New Zealand (bpac^{nz}), "The detection and management of patients with chronic kidney disease in primary care"
- bpac^{nz}, "The Chronic Kidney Disease (CKD) and Non Contact Consult"
- Complaints policy (Appendix B)
- Clinical Recall and Screening Policy GP Clinic (updated April 2018)

- bpac[nz], Chronic Kidney Disease (CKD) module

Internal review of care

62. Dr C, the Chief Medical Advisor to the organisation that owns and operates the medical centre, undertook a review of the care provided by Dr B, and advised the following:

- Chronic kidney disease progression is "silent", meaning it is difficult for sufferers to be aware of symptoms until the disease is well advanced. Patients with chronic kidney disease are expected to be given lifestyle advice as per the bpac[nz] guidelines.[21]
- The management and monitoring of abnormal eGFR is the responsibility of the ordering practitioner in the first instance, or, in their absence, the practitioner delegated to review results. Referral to specialties is also the responsibility of the attending practitioner, and there are policies in place regarding safety-netting advice.
- The July 2015 renal function tests show that at that stage Mr A had chronic kidney disease.[22] Follow-up should have occurred within one to two weeks, and repeat renal function tests and further investigations (including renal ultrasound and/or specialist referral) should have been undertaken.

63. Dr C recommended that Dr B complete an audit of 12 months' renal function testing within his enrolled patients at the medical centre; upskill in the area of interpretation and management of renal impairment[23] at the time of consultation; and consider a system approach to monitoring.

64. Dr C concluded:

> "[Dr B] failed to understand the real or potential severity of [Mr A's] renal dysfunction in July 2015 and at subsequent consultations up and until the acute referral to [the public hospital] in November 2019 … In doing so, he also failed to undertake appropriate further testing from July 2015 …"

Responses to provisional opinion

65. Mr A's family, Dr B, and the medical centre were given an opportunity to comment on relevant sections of the provisional opinion. Where appropriate, their comments have been incorporated into this report.

The family

66. Mrs A told HDC that reading the "information gathered" section of the provisional opinion was difficult, and that it made her feel like Mr A and her family were "completely let down" by Dr B and the medical centre.

[21] bpac[nz], "Detection and Management of Chronic Kidney Disease".
[22] Stage G2 (mildly decreased kidney function) or G3a (mildly to moderately decreased kidney function) according to the bpac[nz] "Detection and Management of Chronic Kidney Disease" publication.
[23] As per the bpac[nz] CS, CKD module.

67. Mrs A reaffirmed that Mr A would never have taken medication that would cause problems for him. She said that she recalled a blood test form on the fridge on one occasion that Mr A did not get completed, and she said that his reason for this was "what's the point I never hear back from them and nothing ever gets done".

68. In conclusion, Mrs A told HDC that she was happy to see the changes that have been made since these events, and she hopes that her complaint will prevent other families going through a similar situation in the future.

Medical centre

69. The medical centre advised that it accepted the Commissioner's findings.

Dr B

70. Dr B told HDC that the process of the investigation has been difficult. He stated:

> "I fully respect and acknowledge the importance of the issues and I live with the regret and sorrow over how I am perceived and what occurred … I have reflected on what you have written and can assure you that the changes recorded in your opinion are embedded in my practice and thinking."

71. Dr B said that he has reflected on and learnt from this complaint, and has made changes to his systems and his practice as a result, and that he has had no further adverse events since.

Opinion: Dr B — breach

Introduction

72. This report relates to the standard of care provided to Mr A by Dr B in relation to Mr A's declining kidney health and eventual diagnosis with Stage 4 kidney disease. As part of my assessment of this case, I sought in-house clinical advice from GP Dr David Maplesden. Dr Maplesden said that he agrees with the medical centre's review undertaken by Dr C. Dr Maplesden advised:

> "I believe this review accurately reflects [Mr A's] management as indicated by the clinical documentation, and the variation from accepted practice. The remedial measures recommended in [Dr C's] report are appropriate and I have no additional measures to recommend."

73. This report highlights the need to ensure that tests are followed up, and that adequate staging (examinations and tests to determine the extent of an illness) is undertaken to support timely diagnosis and management. The report also emphasises the importance of good communication and robust clinical documentation. In my opinion, a number of oversights in Dr B's care contributed to a delay in Mr A's diagnosis with Stage 4 kidney disease. These are set out below.

Investigation and management of declining renal function

Key consultations

July 2015

74. On 21 July 2015, Dr B ordered renal function blood tests for Mr A on learning of his long-term use of NSAID medications for chronic back pain. On 23 July 2015, the results showed that Mr A had impaired renal function, with an eGFR of 60. Dr B told HDC that at that time, he considered that the cause of Mr A's impaired renal function was his self-reported use of NSAID medications.

75. Dr Maplesden advised that unexpected and impaired results of this nature warrant further investigation to clarify the stage of renal impairment and ensure that the potential for further renal damage is limited. Dr Maplesden advised that accepted practice on this occasion would have been for Dr B to initiate further investigations to clarify the stage of Mr A's renal function by way of an ACR test, plus the implementation of a structured management plan based on the results of the further staging (as per bpac^{nz} guidelines) to limit further damage. However, this did not occur.

76. Dr Maplesden considers that the failure by Dr B to notify Mr A of the potential significance of his results (which is discussed in more detail below), in conjunction with the failure to commence investigations and implement a management plan, represents a moderate departure from accepted practice.

November 2015–June 2016

77. Mr A presented to Dr B again on 5 November 2015, but Dr B did not initiate further renal function investigations or provide Mr A with a form for further renal blood tests on this date. Dr Maplesden advised that the failure to investigate the cause of Mr A's impaired renal function further at this time represents a moderate departure from accepted practice. Dr Maplesden also commented on Dr B's overall care of Mr A, and was critical that Dr B failed to implement a structured management plan for Mr A. I accept this advice.

78. Dr Maplesden identified a further missed opportunity for Dr B to have investigated Mr A's renal function in June 2016 when the renal blood test results showed "chronically impaired but stable renal impairment". Dr Maplesden said that it would have been appropriate for Dr B to consult the bpac^{nz} guidelines to influence his management of Mr A.

February–September 2017

79. Renal function tests ordered by Dr B on 15 February 2017 showed a further deterioration in Mr A's renal function. Dr B annotated the result: "… renal [ultrasound] ordered". However, the ultrasound was not ordered until 14 March 2017.

80. Dr Maplesden advised that ultrasound referral was not an unreasonable strategy, but Dr B had still not ordered an ACR test to enable accurate staging of kidney function. Dr Maplesden said that accurate staging was necessary to influence subsequent management and surveillance of Mr A. Dr Maplesden advised that, taking into account Mr A's history, the failure by Dr B to assess the degree of renal impairment further by way of an ACR test was "a significant oversight". I accept Dr Maplesden's advice.

81. On 14 March and 10 April 2017, Dr B provided Mr A with laboratory forms for further blood tests, but still did not initiate an ACR test to enable accurate staging. The renal ultrasound completed on 23 April 2017 did not show any structural abnormalities that could have accounted for the impaired renal function (and which, if present, could have rendered the ACR test less necessary).

82. Dr Maplesden advised that leaving aside the issue of incomplete staging of Mr A's kidney disease (of which he is critical) Mr A's management over this period was reasonable in part (for example, instructions to limit NSAID use, and the prescribing of prednisone as alternative management for gout). However, in the absence of accurate staging it is not possible to determine whether there was adequate ongoing surveillance and management of Mr A's renal function over this period, and whether or not it was appropriate for Dr B to manage Mr A in primary care.

<u>February 2018</u>

83. Regarding Dr B's management of Mr A on his visit of 8 February 2018, and Dr B's intention to seek specialist advice, Dr Maplesden advised:

> "[I]t was reasonable for [Dr B] to seek specialist advice regarding [Mr A's] slowly deteriorating renal function, particularly given [Mr A's] young age, but it was not critical to wait for further blood tests once this decision had been made. It is apparent the referral was never made but had [Dr B] consulted the relevant Health Pathway he would have obtained the information required to appropriately manage [Mr A]."

84. I accept this advice.

<u>October 2019</u>

85. On 16 October 2019, Mr A presented to Dr B again and was provided with a laboratory form for repeat renal function tests. Mr A had not had the tests performed by the time of his next review on 18 November 2019. By this stage, renal function tests had not been completed since May 2017. Dr Maplesden advised: "The 19-month delay in repeating renal function tests I think reflects the overall lack of a structured management plan with respect to [Mr A's] impaired renal function."

86. I accept this advice.

Management of test results

87. Dr B requested renal function tests for Mr A on eight occasions from 21 July 2015 to 16 October 2019. Dr B told HDC that he also requested an ACR test on one occasion on 17 July 2018 (but this was not recorded in the notes). Mr A completed the blood tests on five occasions,[24] but the tests requested on 14 March 2017,[25] 17 July 2018, and 16 October 2019

[24] Results were received on 23 July 2015, 1 June 2016, 15 February 2017, 18 May 2017, and 12 March 2018.
[25] As noted in footnote 12, it is not possible to confirm whether the blood tests that were missed were those ordered on 14 March 2017 or 10 April 2017; however, results were received in May, which suggests that it was the March tests that were missed.

were not completed. Further, the ACR test that Dr B said he ordered on 17 July 2018 was not completed.

Following up missed/overdue tests

88. Mr A told HDC that he does not recall receiving any reminders or follow-ups from Dr B about completing the ordered blood tests. Mr A said that he presented to Dr B yearly around his birthday, and would have blood tests completed at that time. I note that although Mr A presented to Dr B when health concerns arose, and on most occasions completed ordered blood tests promptly, on three occasions[26] this did not occur.

89. Conversely, Dr B told HDC that he uses a number of "tracking modalities" to prompt follow-up, and he recalls following up with Mr A on numerous occasions, and emphasising the importance of completing the requested tests (but did not document these attempts). Dr B said that the response from Mr A "was not to refuse but to indicate that the tests would be attended to when commitments allowed". Dr B stated that he had to respect Mr A's autonomous right not to consent to having blood and urine tests done, but that he did inform Mr A of the reasons for, and advisability of, having the tests done promptly.

90. Despite Dr B's comments about his follow-up of Mr A's missed tests, he accepted that he did not use formal tracking processes in Medtech32 (electronic patient management software) at the time. I also note that no record was kept of Dr B's apparent follow-up with Mr A regarding his overdue test results (for example, no records of SMS texts, telephone calls, or letters).

91. Dr Maplesden advised that due to the lack of documentation, two scenarios were possible; either a) Dr B did remind Mr A of the overdue tests but Mr A did not follow through (in which case he would be only mildly to moderately critical of the failure to document the follow-up attempts); or b) there was no attempt to follow up with Mr A (in which case he would be moderately critical).

92. The Royal New Zealand College of General Practitioners (RNZCGP) Foundation Standard (Indicator 23) includes the requirement to have effective systems for the management of clinical investigations. The indicators for the standard include that "[t]he practice can demonstrate how they identify and track potentially significant investigations and urgent referrals", and that "[a]record is kept of communications with patients informing them about test results".

93. I consider it the responsibility of practitioners to have robust systems in place to remind patients of the need to complete requested blood tests. I note that I have conflicting evidence before me, where Dr B states that he had several tracking modalities in place and that follows-up were done (but not recorded). However, Mr A says that he does not recall any follow-up. There is a lack of documented evidence of any follow-up having occurred, and at the time of these events Dr B was not using a formal tracking system (such as Medtech) to track such results. Dr B has not provided this Office with details of what tracking

[26] 14 March 2017, 17 July 2018, and 16 October 2019.

modalities he was using, but has maintained that he did remind Mr A of the need to get his blood tests done on several occasions, but that he had to respect Mr A's right to autonomy. On balance, I am unable to make a finding on whether Dr B did attempt to remind Mr A of his overdue blood tests.

94. However, as Dr Maplesden advises, Dr B should have documented all attempts (assuming those efforts occurred) to remind Mr A of his overdue blood tests.

95. I accept Dr Maplesden's advice that this represents a mild to moderate departure from an accepted standard of care, and am critical of Dr B's lack of documentation of his attempts to remind Mr A of his overdue tests.

Discussion of test results

96. For the renal function tests ordered and completed on 21 July 2015, 19 May 2016, and 8 February 2018, there is no clinical documentation recording that Dr B informed Mr A of his results. For the test ordered on 15 February 2017, Dr B documented a discussion with Mr A advising of his eGFR a month later on 14 March 2017. For the blood test ordered on 14 March 2017, there is no record of the result being discussed with Mr A until 17 July 2017, some two months after the test had been completed by Mr A in May 2017.

97. Mr A told HDC that he recalls a conversation with Dr B about his kidney dysfunction at some stage, in which Dr B remarked that he "ha[d] the kidneys of a 60 year old" and that the situation would be monitored. However, Mr A said that he was not alerted to the significance of the test results. Conversely, Dr B told HDC that he raised the issue of Mr A's renal function at most of his consultations with Mr A.

98. Dr Maplesden advised that Dr B's communication of test results to Mr A appeared to be opportunistic and often well after the results were received, rather than there being any structured approach. For example, Dr B has stated that the July 2015 test results, which showed reduced eGFR for a young man and an elevation in creatinine, were not discussed with Mr A until November 2015 (according to Dr B, such discussion was not recorded).

99. With respect to the July 2015 test results, Dr Maplesden advised that accepted practice would be to notify the patient of the new detection of impaired renal function promptly. Dr Maplesden stated:

> "I believe that failure by [Dr B] to notify [Mr A] of the potential significance of his results and to follow up the results in an appropriate fashion would be met with moderate disapproval by my peers."

100. I accept Dr Maplesden's advice.

Intention to refer to specialist

101. On 8 February 2018, a blood test laboratory form was provided to Mr A by the practice nurse (at Dr B's request). The test was undertaken on 12 March 2018 and showed a modest

deterioration in eGFR.[27] Dr B annotated the result: "Send for advice from physicians." Dr B told HDC that he elected to repeat the blood tests before seeking specialist advice regarding ongoing management of Mr A's renal function.

102. As discussed above, on 17 July 2018, Dr B provided Mr A with a form for repeat blood tests. However, these tests were not completed by Mr A, and there is no record in the clinical notes of any tracking of the tests, or of any reminder having been sent to Mr A regarding the need to complete the tests. Dr B suggested in his response to HDC that it was the lack of completion of these tests that meant that no referral occurred. Dr B stated: "Tracking mechanisms were in place to ensure that prompt referral would have taken place had the requested blood and urine tests been done on an earlier occasion."

103. Dr Maplesden is critical that once the decision was made by Dr B to refer Mr A to a specialist, this, together with current test results and his desire for further blood tests before referral, was not discussed with Mr A. In addition, given that Dr B was waiting on test results prior to seeking specialist advice, Dr Maplesden was mildly to moderately critical that there was no formal tracking in place.

104. Dr Maplesden advised:

> "The tests were requested, and intention to refer noted in July 2018, yet the referral had not been completed by October 2019 because required blood and urine results were not forthcoming. I believe that this was an unacceptable delay that would be met with moderate disapproval by my peers [if there was no attempt to remind Mr A of his overdue blood and urine tests]."

105. However, Dr Maplesden said that if Dr B had reminded Mr A of the necessity of undergoing the tests but Mr A declined to do so, given the potential seriousness of late identification of advanced kidney disease, Dr Maplesden would expect there to have been some documentation related to Mr A's apparent decision to decline his investigations and referral. In this case, Dr Maplesden would be mildly to moderately critical that the above was not done.

106. As discussed above, Dr B did not have in place any formal tracking to manage test results, and did not document any attempts to follow up Mr A's overdue tests in July 2018. There is also no documented evidence that Dr B communicated to Mr A the importance of undergoing the tests in July 2018 in light of his intention to refer him to a specialist on receipt of further blood test results.

107. Noting the importance attached to these blood results, in that they were to inform and activate specialist referral, and the lack of documentation, and noting Mr A's evidence, I conclude that Dr B did not convey his intention of specialist referral to Mr A, and the importance of these tests to the referral process. I accept my expert's advice and am critical of this failure.

[27] A decrease of 7ml/min from the previous result since May 2017.

Management of NSAID medications

108. Dr B told HDC that on 21 July 2015, he advised Mr A that long-term usage of NSAID medications can cause a reduction in kidney function, and he raised it with Mr A again on 5 November 2015. It is also documented that on 14 March 2017 Dr B "[c]autioned [Mr A] to limit NSAID usage given eGFR". Conversely, Mr A told HDC that he does not recall being made aware of the risks of continued NSAID use. Mr A said that he had been taking NSAID medications for years for ongoing back pain, and that Dr B did not tell him to stop the use of the medications or that the long-term use of them was concerning.

109. Dr Maplesden noted that Dr B provided Mr A with prescriptions for NSAID medications on the following occasions: 21 July 2015, 11 January 2017, 15 February 2017, and 17 July 2017. Whilst there are multiple mentions of discussions about avoiding NSAIDs, there is no documentation of such a discussion between 2015 and February 2017.

110. Dr Maplesden advised that the clinical notes from 5 November 2015 do not support Dr B's recollection that he discussed the use of NSAIDs with Mr A, particularly Dr B's note: "He has Brufen at home — happy to rescript at any time." I agree with Dr Maplesden's observation that this particular note calls into question whether the importance of avoiding NSAIDs in the context of renal impairment was presented adequately.

111. Dr Maplesden noted that it would have been preferable for Dr B to prescribe alternatives to an NSAID medication on 11 January 2017 to manage an acute attack of gout, in light of the deterioration in Mr A's renal function since the test eight months previously. However, Dr Maplesden considers that the provision of allopurinol was a reasonable strategy for gout prevention, provided renal function was monitored.

112. I accept Dr Maplesden's advice, and acknowledge that the use of allopurinol for the management of gout was acceptable, provided Mr A's renal function was monitored (noting, however, that by this time Dr B's failure to assess the degree of Mr A's renal impairment was a significant oversight (as discussed above)). However, I also accept that it would have been preferable to prescribe a non-NSAID medication to Mr A for this purpose, particularly given Mr A's continuing renal function deterioration.

113. Dr Maplesden advised that he would be moderately critical if advice was not provided on the nephrotoxic potential of NSAIDs and to limit use as much as possible from at least July 2015, and that best practice is to document the provision of such advice.

114. I acknowledge Dr B's comments that in July 2015 and November 2015 he advised Mr A that the long-term use of NSAIDs can cause a reduction in kidney function, and that in March 2017 Dr B documented that he had cautioned Mr A to limit NSAID usage given his eGFR. Notwithstanding the above, I note Dr B's prescribing of NSAID medications on 21 July 2015, 11 January 2017, 15 February 2017, and 17 July 2017; clinical notes from 5 November 2015 that state "has Brufen at home — happy to rescript any time" (which occurred after impaired renal function had been identified); and Dr B's choice to prescribe an NSAID gout prevention medication rather than a non-NSAID medication.

115. I am satisfied on the evidence that Mr A did not fully understand the need to limit his use of NSAIDs given their toxicity to the kidneys. I also accept, based on the contemporaneous clinical documentation, that from February 2017 Dr B did advise from time to time the importance of limiting NSAID usage. However, between 2015–2017, there is no such documentation, a clinical note indicates that Dr B was happy to rescript Brufen, and there were several prescriptions of NSAID medications. I therefore consider it more likely than not that, in this period, Dr B did not educate Mr A adequately on the need to limit his use of NSAIDs in light of his decline in renal function, and the significance of this advice.

116. Accordingly, I accept Dr Maplesden's advice, and am critical of the apparent lack of care taken by Dr B to limit the risk of Mr A's continued use of NSAIDs when he had deteriorating kidney function.

117. As a final point, I acknowledge Dr Maplesden's advice that "best practice" would be to document the provision of advice to limit the use of NSAID medications in light of impaired renal function. At the outset, I wish to acknowledge that it is not my role to hold clinicians to a "best practice" standard of care, but rather to an accepted standard of care. Accordingly, I would not be critical of the failure to document in isolation. However, in the specific (alleged) circumstances of this case, where Dr B says he continued to educate Mr A about the importance of limiting his NSAID usage, but felt that Mr A was not accepting of this advice, it would have been prudent for Dr B to have documented that these conversations had occurred (prior to February 2017).

Conclusion — breach

118. Overall, as detailed above, there were a number of deficiencies in the care provided to Mr A by Dr B, including:

- The failure to advise Mr A of his deteriorating renal function (as evidenced by his test results) in a timely manner.
- The failure to further investigate Mr A's impaired kidney function, including determining the stage of the decline, and implement a robust ongoing management plan.
- The failure to convey to Mr A effectively the risk of ongoing use of NSAID medication in the context of impaired renal function.
- The failure to document attempts to follow up on Mr A's overdue test results adequately, and Dr B's failure to convey his intention of specialist referral being dependent on such tests being undertaken.

119. I note Dr Maplesden's advice:

> "I believe [Dr B's] overall management of [Mr A's] renal disease, particularly the failure to undertake appropriate investigations early on to enable staging of the disease and an appropriate structured management and surveillance plan, departed from accepted practice to a moderate degree."

120. I agree with Dr Maplesden's advice, and consider that collectively the above deficiencies in Dr B's care represent a failure to provide services to Mr A with reasonable care and skill. Accordingly, I find that Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[28]

121. In addition, by not being adequately informed of his deteriorating renal function test results in a timely manner and the risk of ongoing use of NSAID medication in the context of impaired renal function, Mr A was not provided with information that a reasonable consumer in his circumstances would expect to receive. Accordingly, I find that Dr B breached Right 6(1) of the Code.[29]

Other comment

Appointment between 16 October and 18 November 2019

122. Mr A told HDC that he recalls an appointment between 16 October 2019 and 18 November 2019, when he presented with a headache and vomiting and was prescribed paracetamol by Dr B. Dr B told HDC that he has no recollection of such an appointment taking place, and there is no record of the appointment in either the clinical notes or in the appointment register. However, Dr B confirmed that paracetamol was prescribed for shoulder pain during the consultation of 16 October 2019. Having evaluated the evidence I am unable to make a finding to the required standard of proof that there was another undocumented appointment between 16 October and 18 November 2019.

Communication during 18 November 2019 appointment

123. Mrs A told HDC that she raised significant concerns with Dr B during the 18 November 2019 consultation, including that Mr A might have a brain tumour, and that Dr B laughed at her. Dr B told HDC that the appointment on this date was complex and prolonged, with thorough neurological and cardiovascular assessments and a management plan that included physician referral, a CT referral, blood tests, 24-hour blood pressure monitoring, and the commencement of a blood pressure medication.[30] Dr B denies having laughed at Mrs A or having told her to purchase Nurofen from the supermarket.

124. Dr Maplesden advised that the notes appear to support Dr B's recollections of this visit, and he considers that an appropriate standard of care was provided. I am unable to make a finding on this particular issue. However, it is clear that by this point the therapeutic relationship between Dr B and Mr A was strained and there was an apparent breakdown in communication. I encourage Dr B to reflect on this.

[28] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[29] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"
[30] Quinapril.

Opinion: Medical centre — no breach

125. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. Dr Maplesden advised: "I am unable to identify any deficiencies at a practice/organisational level that contributed to the issues raised by [Mr A] regarding his management." I accept that the medical centre had appropriate policies in place at the time of these events, and I consider that the errors made by Dr B were individual failings and do not indicate broader systems issues at the medical centre. However, I have identified some deficiencies in the medical centre's complaint management on this occasion.

Complaint management — adverse comment

126. On 20 February 2020, following Mr A's diagnosis with Stage 4 kidney disease, Mrs A delivered a letter of complaint to the medical centre (addressed to Dr B) on behalf of Mr A. Mrs A delivered another letter a month later on 20 March 2020 as the medical centre had not responded to her concerns. The medical centre responded by email the same day, and told Mrs A that the letter would be responded to over the next week. Due to various delays within the medical centre, no letter of response was provided to the family. The medical centre sent several emails explaining the delays, but these were not received by Mrs A. The medical centre told HDC that staff also had telephone conversations with Mrs A and Mr A's father but no details of those conversations were documented.

127. The practice manager said that Dr B read the letter and supplied it to her on the same date, at which stage it was treated as a request for information rather than a complaint. However, the Complaints Policy (in place at the time of these events) defines a complaint as follows:

> "A consumer complaint is any expression of dissatisfaction received from a client, patient, visitor, family member … regarding an event that has occurred, a system or process with [the medical centre] or a staff member."

128. I consider that Mr A's complaint to the medical centre was an "expression of dissatisfaction". However, I accept that it was not regarded as such when first considered by the medical centre.

129. Right 10 of the Code, and the medical centre's Complaints Policy state that a complaint can be received in writing or verbally. The Complaints Policy also states that written complaints are to be forwarded to the complaints officer (practice manager), and to be attached to an incident form for action, which is to be done by the end of the day on which the complaint is made. Right 10 and the Complaints Policy also state that all complaints are to be acknowledged within five working days of receipt, and that all complaints are to be investigated within 10 working days of acknowledgement to decide whether the complaint is justified.

130. Taking the above into account, it is evident that the medical centre did not follow its own Complaints Policy in the management of Mr A's complaint. I am concerned that the medical centre failed to respond appropriately to the family's concerns. However, I also note the

unfortunate circumstance that the emails sent from the medical centre did not reach Mrs A, but am unable to find the medical centre at fault for this.

131. Considering all the above, I favour an educational approach in this case, and I remind the medical centre of its obligations under Right 10(3) of the Code: "Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints." I encourage the medical centre to reflect on my comments in this regard and to ensure that all staff are familiar and compliant with its Complaints Policy.

Changes made

Dr B

132. Dr B told HDC that since these events, he has made the following changes to his practice:

- He consistently uses the bpac^{nz} Chronic Kidney Disease module.
- He allocates time after clinic to ensure that he has fulsome notes and a complete record of his daily consultations.
- He has a lower threshold for referral to secondary care for further investigations.
- He has enhanced compliance with testing in reluctant patients.
- He uses the graph in Medtech Evolution to graph results, including kidney function results and urine albumin:creatinine ratio (ACR) results.
- He is more meticulous when annotating results, noting abnormal results, and documenting a management plan.
- He records requests for urine ACR tests electronically rather than writing "Urine ACR" on the request form.
- He supplies patients with a labelled urine bottle in a specimen bag to improve compliance with the ACR test.
- He has re-read the Medical Council of New Zealand (MCNZ) publication "Ending a doctor–patient relationship" (updated February 2021).
- He documents texts, telephone calls, and letters in his notes when attempts to follow up on test results are made.
- He uses e-Forms (Access Healthscope e-Order), which have an automatic built-in tracking facility.
- He puts a note into his daily appointment schedule, particularly if he is going to attend to a reminder on the same day. He uses this as a reminder to set tasks or recalls later in the day. In particular he uses this method to remind him to send ERMS messages to the hospital of other providers.
- He uses "tasks" and "recalls" within the Medtech Evolution program.

- He has an exercise book with columns labelled "name" and "task", which he uses during the day, as it is often quicker to record a task in this way on a busy day.
- He spends between 60 and 120 minutes a day managing results and letters, and is diligent in attending to this task.
- He encourages his patients to complete requested tests promptly.

133. Dr B also completed the following, as recommended in Dr C's review of the case:

- An audit of the renal function testing of his enrolled population. All patients are on active recalls for regular renal function testing every three months, or more often if required.
- He worked through the bpac^{nz} Chronic Kidney Disease (CKD) module and "The detection and management of patients with chronic kidney disease in primary care", and has discussed his management of CKD through the active peer groups to which he belongs. He has also reviewed the CKD information within UpToDate extensively.

Medical centre

134. The medical centre told HDC that it has undertaken the following as a result of this complaint:

- Conducted an audit to ensure that appropriate classification was in place for individuals with an eGFR below 60.[31]
- Conducted a further audit with a query retrieving all patients who were classified as chronic renal failure to double check that they had all had eGFR results within the last three months. All but one had had their tests done and monitored. The patient who had not had tests done had declined active monitoring of their condition.
- Management has been conducting the above audit each month to ensure that the process is working as it should.
- Revised its "Recall and Clinical Screening Policy" to specifically incorporate management of chronic kidney disease.
- Clinicians within the practice have been reminded about the use of the bpac^{nz} Decision Support Chronic Kidney Disease Module.
- There has been considerable peer discussion and review in relation to chronic kidney disease patients within the practice.
- The practice now has access to E Orders for laboratory tests and can check electronically to see whether a requested test has been completed or if a result has been received. The practice now phones, text messages, or emails individuals to remind them to have their tests done.

[31] Patients who were assessed as having renal impairment were checked to ensure that appropriate classifications were in place. 25% of the individuals who were identified as in chronic renal failure were not classified as being so. The audit included all patients within the practice. The classifications were then updated within the practice management system.

- The practice is working on rolling out a patient portal so that results are made available to patients in a timely manner and appropriate notification of abnormal results occurs.
- The practice agreed that if a clinician feels that the therapeutic relationship with a patient is not working for either party, the practice will manage the patient as a team.

135. The medical centre told HDC that it shifted from Medtech32 to Medtech Evolution in March 2020 (after these events), and that the clinical team utilises the recall system within Medtech, setting reminders for tests to be repeated for all chronic conditions.

Recommendations

136. In light of the extensive changes already made by Dr B, and guided by Dr Maplesden's comments that the remedial actions recommended by Dr C (and completed by Dr B) were appropriate, I recommend that Dr B:

a) Provide a written apology to Mr A and his family for the failures identified in this report. The apology is to be sent to HDC, for forwarding to Mr A, within three weeks of the date of this report.

b) Conduct an audit of a random sample of 20 patients to ensure that clinical documentation is of an appropriate standard, according to the Medical Council of New Zealand practice guidelines. The results of the audit are to be provided to HDC within three months of the date of this report. If the audit does not identify 100% compliance, Dr B is also to report back to HDC on what actions have been taken to address the issues.

137. I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

138. In light of the extensive changes already made by the medical centre following these events, I recommend that the medical centre:

a) Provide a written apology to Mr A and his family for the issues identified in relation to its communication following Mrs A's complaint. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

b) Conduct a further audit (in light of its previous findings that 25% of patients with an eGFR below 60 were not classified appropriately as having chronic kidney disease) to ensure that all patients with an eGFR below 60 are classified appropriately. The medical centre is to report back to HDC on the results of the audit within three months of the date of this report. If the audit does not identify 100% compliance, then the medical centre is to report back to HDC on what actions have been taken to address the issues.

c) Use an anonymised version of this report as the basis for communication and complaints management training for staff. Evidence of this training is to be provided to HDC within six months of the date of this report.

Follow-up actions

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

140. 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 it will be advised of Dr B's name.

141. 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.

Appendix A: In-house clinical advice to 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 [Mrs A] about the care provided to her husband, [Mr A], by [Dr B] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the following information: complaint from [Mrs A]; response from [Dr B] to [Mr A]; GP notes [the medical centre]; response from manager [the medical centre]; external review of complaint [Dr C]; clinical notes [DHB] (renal unit).

2. [Mrs A] states in her complaint: *In November 2019 [Mr A] was diagnosed with stage 4 kidney disease at the hospital, when his specialist reviewed his case he could date it back to 2015 from his blood tests that he was in early stages of kidney disease. Our GP never made us aware of the kidney problems, never referred us onto a kidney specialist and kept prescribing medication that was damaging his kidneys more*. In a letter to GP [Dr B] dated 18 February 2020, [Mr A] notes his eGFR[1] was 59 in 2015, 49 in 2017 and 17 in November 2019. He states: *I know you referred me for an ultrasound and it came back 'normal' other than advising I had small kidneys …* [Mr A] queries why he had no further investigations performed and *why was I not informed in 2017 that I had kidney disease and was already in stage 3? Why were you still prescribing me brufen if in fact I had kidney problems …* [Mr A] expresses concern his blood pressure was not taken when he presented with headaches just prior to his hospital admission in November 2017, and that he was advised to take Nurofen for the headaches.

3. The [DHB's] renal clinic report dated 16 December 2019 includes the following history: [Mr A] *has had progressive renal impairment for five years. He was aware his kidney function was abnormal but didn't appreciate the significance of this. In November 2019 [Mr A] developed severe headaches associated with photophobia and vomiting. A blood pressure taken at work was high, and he saw his GP for further investigation. His creatinine was found to be high and [Mr A] was referred into [the public hospital]. A renal ultrasound showed a left kidney of 82 ml and a right kidney of 88 ml and mildly increased cortical echogenicity. It was noted that [Mr A] had been using ibuprofen for the better part of five years for chronic back pain, which has fortunately now settled down. [Mr A] now knows to avoid non-steroidal anti-inflammatory drugs. [Mr A] has no history of urinary tract infections as a child or any nocturnal enuresis. He has never noted haematuria in his life, but does note his urine goes dark yellow during respiratory tract infections. He has never had a rash, nasal symptoms or asthma or joint pains and has no family history of renal disease. He has recently lost his appetite and lost around 5kg*. [Mr A] was diagnosed with Stage 4 chronic kidney disease (CKD) likely secondary to IgA nephropathy with anaemia secondary to chronic renal impairment. He is currently

[1] Estimated glomerular filtration rate, units mL/min/1.73m^2, reference range per the laboratory is recorded as: *The GFR range for a young adult male is 87–167. From age 30, values fall by approximately 1mL/min/year*

being assessed for kidney transplant with end stage kidney predicted *within the next year or two.*

4. External review has been undertaken by [Dr C]. I believe this review accurately reflects [Mr A's] management as indicated by the clinical documentation, and the variation from accepted practice. **The remedial measures recommended in [Dr C's] report are appropriate and I have no additional measures to recommend.** Given the detail in [Dr C's] report, I will limit my comments to review of the consultations in question and quantification of departure from accepted practice. The reference presented by [Dr C] was freely available to all GPs in 2015[2] and is consistent with the current recommendations from local HealthPathways outlined in Appendix 1.

5. Clinical record review: 21 July 2015 — [Mr A] seen for 'annual checkup'. History of chronic back pain with use of ibuprofen and *he has omeprazole at home.* Wt 69kg (BMI 23.9), BP 120/70. Intermittent smoker. Provided with smoking cessation, exercise and dietary advice. Review PRN. Blood tests performed (see results summary below). Script provided for BrufenSR 800mg BD x 60. Renal function test result (23 July 2015) annotated as: *eGFR 60 — 33 year old.*

Comment: In his response, [Dr B] states blood tests were ordered because [Mr A] had been using NSAIDs (Voltaren) prescribed by his previous GP on a relatively long-term basis and it was discussed with him that these can cause a reduction in kidney function. Blood results were evidently not discussed until [Mr A] returned for review on 5 November 2015. The results dated 23 July 2015 showed reduced eGFR for a young man and concomitant elevation in serum creatinine. Whether or not this was felt to be a transient situation related to NSAID use (which was continuing), I believe accepted practice is to notify the patient of such a result (new detection of impaired renal function) promptly and to initiate further investigations to clarify the stage of the renal impairment (detecting and quantifying proteinuria) plus measures to limit further renal damage as per the cited guidance, followed by a structured surveillance and management plan depending on results. I believe the failure by [Dr B] to notify [Mr A] of the potential significance of his results and to follow up the results in an appropriate fashion would be met with moderate disapproval by my peers. The stage of CKD influences recommended management and surveillance as noted in the cited guidance.

6. The next consultation was 5 November 2015 with notes indicating a presenting complaint of left ankle pain (diagnosed as tendonitis) and review of back pain. Management plan is noted as: *Long chat on Brufen for inflammation. X-ray to exclude fracture or other bony pathology* (ankle X-rays organized). *He has Brufen at home — happy to rescript any time.* There is no reference to discussion regarding previous results and no lab form provided for follow-up tests. No prescriptions provided.

Comment: In his response, [Dr B] states that he discussed with [Mr A] *kidney function tests and your usage of ibuprofen and other NSAID medications.* The clinical notes do

[2] https://bpac.org.nz/BPJ/2015/February/ckd.aspx Accessed 7 September 2020

not reflect such discussion and if there was such discussion, it evidently did not result in further investigation of the renal impairment at this time. [Dr B] notes he was *happy to rescript* [Brufen] *any time* which calls into question whether the importance of avoiding NSAIDs in the context of renal impairment was adequately presented. I believe the failure by [Dr B] to further investigate [Mr A's] impaired renal function at this time would be met with moderate disapproval by my peers. I would be moderately critical if advice was not provided concurrently on the nephrotoxic potential of NSAIDs and to limit use as much as possible.

7. [Mr A] was seen in January 2016 with dermatological issues. Consultation notes dated 19 May 2016 include: *In today for review. He wants his lipids done as his mum and another family member are on statins now …* BP 120/78. Blood test form provided. No reference to discussion re previous renal impairment but renal function was rechecked (see results section below) on 1 June 2016 showing stable but impaired renal function. CVRA was performed on receipt of the test results (assessed as 8% 5-year risk) and offer of statins texted to [Mr A]. Renal function result is annotated as: *eGFR 61 — 34 yo.* [Mr A] saw [Dr B] again on 21 June 2016 to discuss initiation of statins and atorvastatin prescribed with *bloods in 3 months.* There is no reference to discussion of renal function.

Comment: [Dr B] does not confirm if renal function tests were discussed but states the results *would be consistent with previous kidney damage, possibly an acute kidney injury.* I believe this was a missed opportunity to further investigate the chronically impaired but stable renal impairment as per the cited guidance. It was certainly appropriate to manage [Mr A's] modifiable cardiovascular risk factors as was done (blood pressure satisfactory at this stage). There is record of a blood test form being provided on 21 June 2016 for the planned three-month follow-up of fasting lipids (no reference to recheck of renal function) but it does not appear the test was completed.

8. On 11 January 2017 [Mr A] presented with shoulder/neck musculoskeletal issues and was referred for acupuncture and provided with prescriptions for Norflex and Brufen 800mg SR BD x 60 tabs. Notes include: *Also, recomment* [sic] *brufen retard as an anti-inflammatory. Open door for review.* It is unclear if the Brufen was recommended or recommenced but there is no reference to discussion of alternative analgesics that might be more appropriate for a patient with renal impairment. On 15 February 2017 [Mr A] presented with right ankle pain and findings consistent with recurrent gout. He had been self-medicating with mefenamic acid. Management was: *Stop Brufen SR, start ibuprofen 200mg TDS* (prescription provided for 2x200mg tabs QID x 200 tabs) *with cautionary guidance. Uric acid, then consider allopurinol. Repeat lipids.* Blood tests were performed with results as noted below. The renal function result is annotated *Allopurinol started, renal U/S ordered.* Allopurinol was prescribed on 24 February 2017 as 100mg once daily. It does not appear the ultrasound referral was made until 14 March 2017.

Comment: There had been a deterioration in [Mr A's] eGFR (decrease of 12 ml/min) and rise in creatinine since the test eight months previously. [Mr A] had yet to have an

assessment of proteinuria to enable accurate staging of his CKD which would in turn influence subsequent management and surveillance. It would have been preferable to prescribe alternatives to NSAIDs for management of an acute attack of gout (eg prednisone) given the deterioration in renal function evident in the test results, but provision of allopurinol was a reasonable strategy for gout prevention provided renal function was monitored. Referral for renal ultrasound was not an unreasonable strategy (but was not urgent) but the failure to further assess the degree of renal impairment by way of urinalysis was a significant oversight.

9. At review on 14 March 2017 [Mr A] complained of nausea with allopurinol. Notes include: *On Brufen for pars defect* [back issue] *— intermittent usage. Note eGFR … A: Elevated uric acid, not tolerating Allopurinol, health pathways consulted → Probenecid — NS Formulary and Health Pathways. Discussed eGFR — he has had no acute event. Cautioned to limit NSAID usage give eGFR — repeat today, I will seek an ultrasound.* BP 120/80. Prescription provided for probenecid 500mg BD and atorvastatin. Lab form was provided for repeat renal function and uric acid and there is reference to renal ultrasound referral. [Mr A] presented again on 10 April 2017 with ongoing right ankle pain (BP 120/80). On this occasion he was referred for ankle X-rays, rheumatology blood tests and further referral made for renal ultrasound. Notes include: *Advised paracetamol QID and ibuprofen for breakthrough pain.* Prescription provided for ibuprofen 200mg ii QID x 200 tabs.

Comment: There was still a failure to check urinary protein excretion to enable accurate staging of [Mr A's] CKD although it is apparent there was discussion on the need to limit NSAID use and alternative strategies were discussed. Gout management was reasonable. There was an intention to monitor [Mr A's] renal function and other blood tests at a reasonable interval although he did not get the tests done until 18 May 2017.

10. Renal ultrasound result dated 23 April 2017 showed a 6mm left renal cyst but was otherwise normal (no structural abnormality to account for the CKD). Repeat renal function tests on 18 May 2017 showed a slight improvement from previous results and were annotated: *Awaiting u/s — stable* although the ultrasound had been completed by this stage. On 17 July 2017 [Mr A] presented with an exacerbation of back pain after an injury. Standard back assessment documented and management included: *He has NSAID at home, Norflex, paracetamol, and ACC. Discussed renal function and u/s findings ….* On 1 September 2017 [Mr A] was again reviewed in relation to his back injury and ACC documentation provided for return to work. On 1 December 2017 [Mr A] was reviewed in relation to a gout flare which was treated on this occasion with prednisone. Notes include: *brief discussion on eGFR stable, and u/s kidneys.* [Mr A] continued to receive prophylactic treatment for his gout and hyperlipidaemia.

Comment: Leaving aside the issue of incomplete staging of [Mr A's] CKD, management over this period was reasonable noting the instruction to limit NSAID use and prescribing of prednisone as an alternative for management of acute gout. However, the absence of accurate staging means it is not possible to determine whether there was adequate ongoing surveillance of [Mr A's] renal function (in terms of frequency of

testing) and whether it was appropriate to continue to manage him in primary care. In the absence of significant proteinuria and noting [Mr A's] adequately controlled blood pressure, treated hyperlipidaemia, absolute and comparative eGFR readings and advice to limit the use of NSAID, ongoing management in general practice with annual assessment might have been a reasonable strategy with low threshold for commencing an ACEI. Conversely, if there was significant proteinuria, much closer monitoring, commencement of an ACEI and consideration of nephrology referral (depending on the degree of proteinuria) might have been considered as per the guidance in Appendix 1.

11. On 8 February 2018 [Mr A] requested a repeat prescription per phone and the practice nurse asked [Dr B] if a follow-up blood test was required (blood form provided in response for renal function and uric acid). The test was undertaken on 12 March 2018 and showed modest deterioration in eGFR (decrease of 7ml/min from previous) since May 2017. The result was annotated: *Send for advice from physicians.* Per [Dr B's] response, he elected to withhold making the referral until the results were repeated, but this was not discussed with [Mr A] until a consultation for a respiratory tract infection on 17 July 2018. BP 120/80. A form for further blood tests was provided on this date. The [medical centre's] response states an ACR was requested on this date but the request form provided lists only renal function blood tests.

Comment: I think it was reasonable for [Dr B] to seek specialist advice regarding [Mr A's] slowly deteriorating renal function, particularly given [Mr A's] young age, but it was not critical to wait for further blood tests once this decision had been made. It is apparent the referral was never made but had [Dr B] consulted the relevant Health Pathway (Appendix 1) he would have obtained the information required to appropriately manage [Mr A]. I am moderately critical that once the decision to refer was entertained, this, together with current results and desire for further blood tests, was not discussed with [Mr A] until he presented for another matter some three months after the results had been received.

12. There is no record of [Mr A] completing the tests organised on 17 July 2018 nor any record of the tests or referral being tracked and [Mr A] reminded of the need to complete the tests. Given [Dr B] was apparently waiting on the results prior to seeking specialist advice regarding ongoing management of [Mr A's] renal function (ie results were of some importance) I am mildly to moderately critical there was no formal tracking in place[3].

13. [Mr A] attended another provider for a travel medical consultation on 15 February and 13 May 2019. He saw [Dr B] regarding an eye issue on 16 July 2019, and on 16 October 2019 presented with a right shoulder problem. He was referred for neck and shoulder X-rays and paracetamol prescribed with reference to: *given past eGFR.* A form was provided for repeat renal function (last result some 19 months previously). Last blood pressure reading was July 2018 and was normal at that time. With reference to

[3] See: https://www.rnzcgp.org.nz/gpdocs/New-website/Advocacy/PB6-2016-Apr-Managing-patient-test-results.pdf Accessed 7 September 2020

the complaint, there is no record of [Mr A] presenting with headache or being advised to take ibuprofen at this consultation. Ibuprofen had not been prescribed since July 2017. [Mr A] had not had the blood tests performed by the time of his next review.

Comment: Had [Mr A] complained of headache on 16 October 2019 I would expect this to have been documented and blood pressure recorded. It was appropriate to recheck renal function given the time since the last test. However, the marked deterioration in renal function observed a month later could not have been foreseen by [Dr B] on the basis of the presenting symptoms recorded on 16 October 2019. **The 19-month delay in repeating renal function tests I think reflects the overall lack of a structured management plan with respect to [Mr A's] impaired renal function.** Given the last prescription for ibuprofen had been July 2017, it appears [Mr A] must have been obtaining ibuprofen from another source (it is available over the counter) if there was ongoing regular intake of the drug in the intervening two years. **If this was the case, [Dr B] might reflect on the effectiveness of his previous discussions with [Mr A] regarding the nephrotoxic potential of the drug.**

14. On 18 November 2019 [Mr A] presented with his wife *to discuss headaches, eGFR and his BP* (elevated at a recent workplace assessment)*. He tells me he has taken a lot of Brufen in the past.* BP noted as 170/94. Neurological examination normal. Initial plan was CT head, physician referral (private), repeat bloods, 24-hour BP monitor and commence ACEI (prescribed quinapril). However, on receipt of the blood tests which showed a marked deterioration in renal function since the previous results, [Dr B] consulted with a nephrologist and [Mr A] was admitted to hospital. PCR dated 18 November 2019 was noted to be grossly elevated and [Mr A] was diagnosed with Stage 4 CKD. Renal ultrasound result dated 19 November 2019 concluded: *Mildly increased cortical echogenicity is a non-specific finding which can be seen with medical renal disease. Kidneys are otherwise basically normal, well preserved cortical thickness, no hydronephrosis.* The working diagnosis was IgA nephropathy.

Comment: [Dr B's] management of [Mr A] at this late stage was reasonable in that he recognised there was a need for urgent specialist review and this was facilitated.

15. Lab results summary

Date	eGFR	creatinine (50-110 umol/L)	Urinary prot:creat ratio (PCR) (<23g/mol)	Haemoglobin (130-175 g/L)	Uric acid (0.20-0.42 mmol/L)	Comment
23/7/15	60	134	-	142		HbA1c normal, lipid profile showed dyslipidaemia (TC:HDL ratio 7.4)
1/6/16	61	131	-	144		HbA1c normal, dyslipidaemia persists
15/2/17	49	156	-	-	0.58	Lipids stable
18/5/17	52	149	-	-	0.32	Lab forms provided 14/3/17 and 10/4/17 for renal function, uric acid
12/3/18	45	167	-	-	0.51	Lab form provided 8/2/18
17/7/18	-	-	-	-	-	Lab form provided for renal function but not performed. No ACR request on form
16/10/19	-	-	-	-	-	Lab form provided for renal function, CBC but not performed.
18/11/19	17	372	404	109		PCR ordered by ED staff
27/11/19	17	366	-	-		Per hospital

16. It is difficult to state that more regular monitoring of [Mr A's] renal function and cardiovascular risk factors would necessarily have altered the trajectory of his renal disease, although earlier recognition of progression of disease, commencement of an ACEI and strict avoidance of NSAIDs might have been of some benefit in the short to medium term. However, I believe [Dr B's] overall management of [Mr A's] renal disease, particularly the failure to undertake appropriate investigations early on to enable staging of the disease and an appropriate structured management and surveillance plan, departed from accepted practice to a moderate degree. Remedial measures have been referred to in section 4.

17. Addenda 24 May 2021 and 19 July 2021

[Dr B] has provided further responses dated 10 May 2021 and 5 July 2021. These responses include the following points:

(i) Although not documented, [Dr B] raised the issue of [Mr A's] renal dysfunction and need to avoid NSAIDs (including over the counter purchases) at most of the consultations he had with [Mr A]. [Dr B] felt the most likely cause of [Mr A's] renal dysfunction was his use of NSAIDs and he actively discouraged such use and eventually ceased prescribing them for [Mr A]. Ibuprofen was suggested as an alternative to Voltaren at a consultation in January 2014 (given the thinking at the time this had a lower cardiovascular and renal risk profile).

Comment: I believe there is documentary evidence suggesting [Dr B] discouraged the use of NSAIDs by [Mr A] from February 2017 but notes between 2015–2017 do not suggest such discussion was undertaken (see s6). This may be a deficiency in clinical

documentation rather than a deficiency in management noting [Dr B's] assertion that it is his practice to discourage long-term use of NSAIDs. I remain moderately critical if advice was not provided on the nephrotoxic potential of NSAIDs and to limit use as much as possible from at least July 2015, and best practice is to document provision of such advice.

(ii) [Mr A] did not always get the blood tests requested performed in a timely manner or at all. This was out of [Dr B's] control. Urine tests were requested in July 2018 but were not performed by [Mr A]. ACR was handwritten on the lab form which is why it was not present on the copy generated for HDC.

Comment: As noted in my initial advice, discussion of abnormal results appeared to be opportunistic and often well after the results were received, rather than there being any structured approach. There is no documentation of attempts made to recall [Mr A] for overdue blood tests (eg SMS text, phone call or letter). [Dr B] states he *had to respect* [Mr A's] *autonomous right to not to consent to having the blood and urine tests done despite his being informed of the reasons for, and advisability of, having them done promptly.* In his later response, [Dr B] states: *I acknowledge that attempts to contact [Mr A] are not documented in my notes. I am very clear that we did follow up. We now do document all attempts. My clear recollection is that when we chased these up, the response was not to refuse but to indicate that the tests would be attended to when commitments allowed.* Noting probably the most critical period of no testing performed between March 2018 and October 2019, there are two scenarios presented (and see section 19):

a. [Dr B] reminded [Mr A] of the overdue tests on a number of occasions but [Mr A] made an informed decision to decline to get the tests done. In this case I would withdraw my moderate criticism of the failure to test over this period, but would be mildly to moderately critical of the failure to document the efforts made to recall [Mr A], including information provided to [Mr A] regarding the importance of the tests.

b. There was no attempt to remind [Mr A] of his overdue blood and urine tests (in relation to the form supplied in July 2018) — moderate criticism remains.

(iii) With respect to tracking of results and earlier nephrology referral, [Dr B] states: *Tracking mechanisms were in place to ensure that prompt referral would have taken place had the requested blood and urine tests been done on an earlier occasion.*

Comment: I would expect a robust tracking process to have identified, within a reasonable length of time, the fact [Mr A] had not had the requested tests done. This may have been identified because the tests were identified as overdue or because completing the referral became an overdue task (in which case the reasons why it was overdue could be detected and addressed). The tests were requested, and intention to refer noted, in July 2018 yet the referral had not been completed by October 2019 because required blood and urine results were not forthcoming. I believe this was an unacceptable delay that would be met with moderate disapproval by my peers if the

scenario described in section (b) above was applicable. If the scenario described in section (a) applies, given the potential seriousness of late identification of advanced kidney disease I would expect there to have been some documentation related to [Mr A's] apparent decision to decline his investigations and referral (per [Dr B's] response) and I am mildly to moderately critical this was not done. However, in that case I would withdraw my moderate criticism of the failure to ensure the referral was completed.

(iv) [Dr B] has outlined the actions he has taken since this complaint and they appear comprehensive and clinically appropriate.

(v) In summary, my criticisms regarding management of [Mr A's] renal dysfunction in 2015 and 2016 remain (s5 and 6). I remain moderately critical of the delay in requesting ACR test (as a means of staging [Mr A's] renal dysfunction) and acknowledge this was requested in July 2018 but not performed by [Mr A]. The standard of [Mr A's] management from 2017 onwards depends on whether or not he made an adequately informed decision to forego or delay tests recommended by [Dr B] as discussed above. If he made an informed decision to decline further investigations I would not be critical of [Dr B's] clinical management over this period (2017–2019) other than the delay in considering/ordering ACR, but I would be critical of the absence of documentation related to attempts to recall [Mr A] for his tests or the discussions that took place in relation to his decision to decline the tests.

18. I have reviewed the response from [the medical centre] dated 2 April 2021. This describes actions taken by the organisation since the complaint and these actions, including clinical audits, staff education on the PMS CKD module and review of relevant policies appear comprehensive and appropriate. I note the Clinical Recall & Screening Policy (GP Clinic) includes: *All recalls are to be documented, with patient contact via SMS txt, phone calls or letters entered on the patient management screen. Inability to make contact with a patient regarding recall must be documented. Recall information about a patient needs to be communicated between the multidisciplinary healthcare team ie GPs and Practice Nurse.* An addition to the policy refers to blood tests for chronic conditions such as CKD: *If patient declines active monitoring or treatment of a chronic health condition, patient & family must sign a letter stating their wishes that is then also signed by the GP and Manager and clearly documented within PMS.* As discussed above, it is not clear from the documentation on file what attempts were made to remind [Mr A] of his outstanding test requests from July 2018 or who provided the reminders. The practice plans to introduce a patient portal which will enable a patient's direct access to their results. I am unable to identify any deficiencies at a practice/organizational level that contributed to the issues raised by [Mr A] regarding his management.

19. In an interview with Mr and [Mrs A] dated 28 May 2021 the following points were raised:

(i) [Mr A] recalls an appointment between those of 16 October and 18 November 2019 when he presented with headache and vomiting and was prescribed paracetamol. His blood pressure was not measured. [Dr B] has responded that he has no recollection of

this appointment and there is no record of an appointment over this period in either the appointment register or the clinical notes. I am able to confirm there is no record of such an appointment in the clinical notes, but that paracetamol was prescribed for shoulder pain following the consultation of 16 October 2019. [Dr B] does not recall [Mr A] complaining of headache and vomiting at this visit and is certain he would have documented the symptoms if such a history was provided. The consultation notes are comprehensive in relation to the shoulder pain, with shoulder and neck X-rays ordered at the time.

(ii) Following the visit of 18 November 2019 [Mrs A] states [Dr B] informed [Mr A] to *go on to the supermarket to get Nurofen to deal with the headaches.* After [Mrs A] raised concerns, [Dr B] agreed to order blood tests. [Dr B] states the appointment was complex and prolonged (over 30 minutes) with thorough neurological and cardiovascular assessment undertaken and management plan including physician referral, CT referral, blood tests ordered, 24-hour BP monitoring ordered and quinapril commenced. The contemporaneous notes appear to support [Dr B's] recollections.

(iii) [Mr A] acknowledged there had been some discussion of kidney dysfunction in the past: *A few years ago, [Mr A] said that [Dr B] had told him 'you have kidneys of a 60 year old'* and that the situation would be monitored. However, the potential significance of the results and advice regarding management was not forthcoming. [Mr A] states he did not recall being made aware of the risks of continued NSAID use. Please note the discussion in s 17(i). Clinical documentation supports [Dr B's] assertion that there was discussion of risks of NSAID use from at least 2017 but [Dr B] might reflect on the effectiveness of this communication given [Mr A's] recollection. It is possible there was inadequate discussion of the potential significance and recommended management of [Mr A's] renal dysfunction given the failure by [Dr B] to follow recommended management guidelines as discussed in the body of this report.

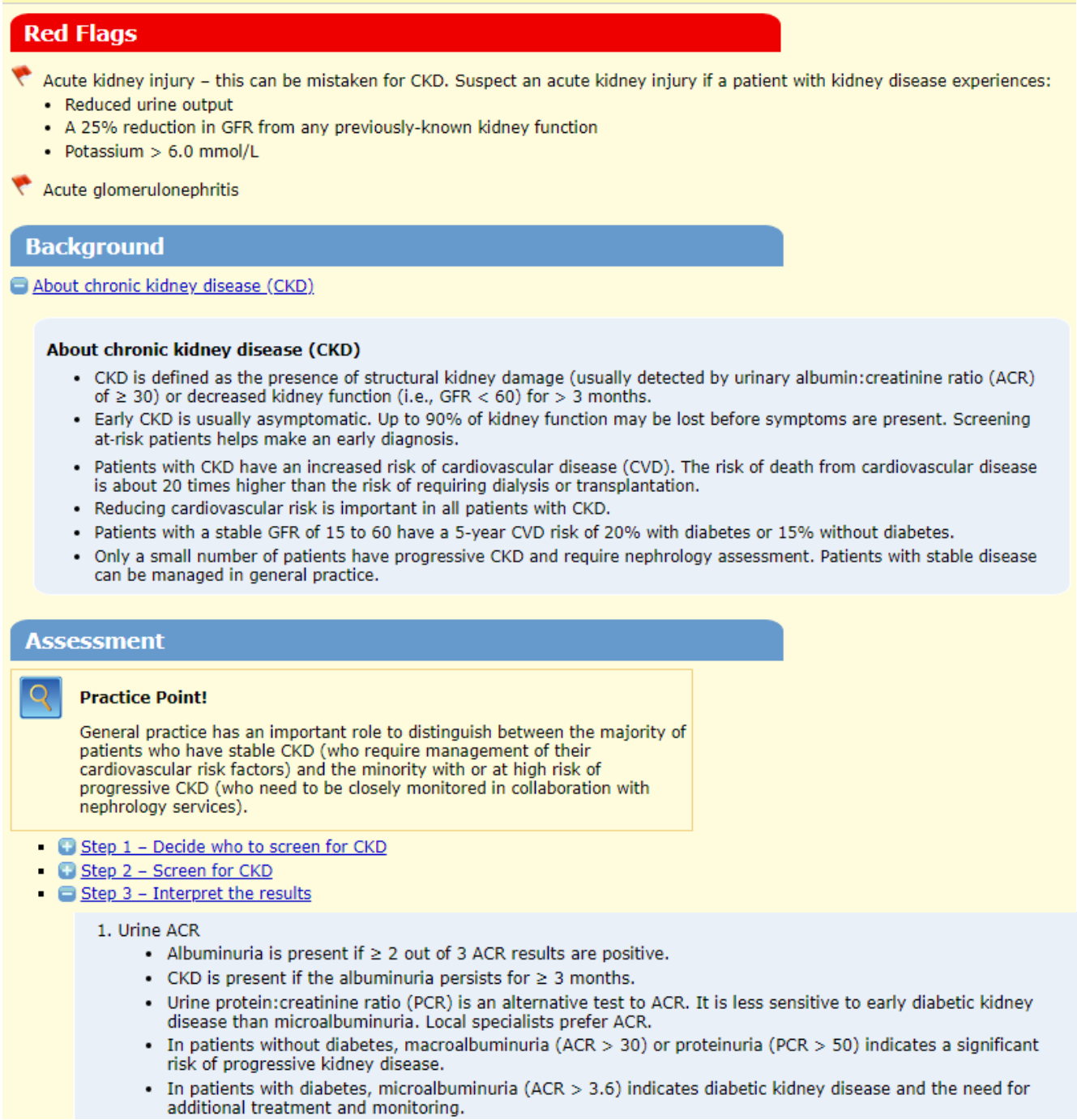
(iv) [Mr A] does not recall getting any reminders or follow-ups from [Dr B] in regard to getting blood tests done. [Mr A] states *he would go to [Dr B] for check ups each year around his birthday and would have blood tests done at that time*.

(v) [Mr A] expresses concern that he was never made aware of the link between gout (which he suffered) and renal disease, and that he was prescribed probenecid inappropriately. Gout prophylaxis was initiated by [Dr B] in February 2017 (allopurinol 100mg daily). This was changed to probenecid (initially 250mg BD up-titrated to 500mg BD) on 14 March 2017 because of intolerance of allopurinol (nausea). [Mr A] remained on probenecid until around August 2019 (last prescription supplied 13 May 2019. I note probenecid was initiated when [Mr A's] eGFR was 49 (15 February 2017) and maintained when results of eGFR were 52 (18 May 2017) and 45 (12 March 2018). This is consistent with accepted practice with precaution to *avoid if eGFR less than 30 mL/minute/1.73m2*[4]. Had [Mr A] been undergoing regular monitoring of his renal function, I would expect probenecid to have been stopped if his eGFR fell below 30

[4] https://nzf.org.nz/nzf_5687 Accessed 19 April 2021

(which it did at some stage between March 2018 and November 2019 but was not detected). Recommended starting dose of allopurinol in renal impairment is: *eGFR 30–60 mL/min/1.73m2, initially 50 mg once daily; increase dose by 50 mg every 4 weeks, if tolerated, until target serum urate is reached (<0.36 mmol/L)* with lower dose recommended for patients with eGFR <30[5].”

Appendix 1[6]



Red Flags

Acute kidney injury – this can be mistaken for CKD. Suspect an acute kidney injury if a patient with kidney disease experiences:

- Reduced urine output
- A 25% reduction in GFR from any previously-known kidney function
- Potassium > 6.0 mmol/L

Acute glomerulonephritis

Background

About chronic kidney disease (CKD)

About chronic kidney disease (CKD)

- CKD is defined as the presence of structural kidney damage (usually detected by urinary albumin:creatinine ratio (ACR) of ≥ 30) or decreased kidney function (i.e., GFR < 60) for > 3 months.
- Early CKD is usually asymptomatic. Up to 90% of kidney function may be lost before symptoms are present. Screening at-risk patients helps make an early diagnosis.
- Patients with CKD have an increased risk of cardiovascular disease (CVD). The risk of death from cardiovascular disease is about 20 times higher than the risk of requiring dialysis or transplantation.
- Reducing cardiovascular risk is important in all patients with CKD.
- Patients with a stable GFR of 15 to 60 have a 5-year CVD risk of 20% with diabetes or 15% without diabetes.
- Only a small number of patients have progressive CKD and require nephrology assessment. Patients with stable disease can be managed in general practice.

Assessment

Practice Point!

General practice has an important role to distinguish between the majority of patients who have stable CKD (who require management of their cardiovascular risk factors) and the minority with or at high risk of progressive CKD (who need to be closely monitored in collaboration with nephrology services).

- Step 1 – Decide who to screen for CKD
- Step 2 – Screen for CKD
- Step 3 – Interpret the results

1. Urine ACR
   - Albuminuria is present if ≥ 2 out of 3 ACR results are positive.
   - CKD is present if the albuminuria persists for ≥ 3 months.
   - Urine protein:creatinine ratio (PCR) is an alternative test to ACR. It is less sensitive to early diabetic kidney disease than microalbuminuria. Local specialists prefer ACR.
   - In patients without diabetes, macroalbuminuria (ACR > 30) or proteinuria (PCR > 50) indicates a significant risk of progressive kidney disease.
   - In patients with diabetes, microalbuminuria (ACR > 3.6) indicates diabetic kidney disease and the need for additional treatment and monitoring.

[5] https://nzf.org.nz/nzf_5681 Accessed 19 July 2021

[6] From HealthPathways section ‘Chronic Kidney Disease (CKD) in Adults’

Guide to albuminuria/proteinuria levels:

ACR (mg/mmol)	PCR (mg/mmol)	24-hour proteinuria (g)	Description
≤ 2.5 in men ≤ 3.5 in women	< 15	0.15	Normal
3.6 to 29	15 to 49	0.15 to 0.49	Microalbuminuria (diabetes only)
30 to 250	50 to 99	0.50 to 0.99	Macroalbuminuria
> 250	> 300	> 3.0	Nephrotic range

2. Urine cells:
   - If pyuria (white cells > 100), haematuria (red cells > 100), red cell casts, or dysmorphic red cells (in the absence of urinary contamination (bacteriuria and/or epithelial cells)), consider acute glomerulonephritis. Discuss with the acute nephrology registrar.
3. GFR
   - Determine if GFR is normal for age.
   - Determine the stage of CKD.

Stage of CKD

Estimated GFR	Stage of CKD	Kidney function
≥ 90 (with structural changes or urine changes)	Stage 1	Normal
60 to 90	Stage 2	Mildly decreased
45 to 59	Stage 3a	Mildly to moderately decreased
30 to 44	Stage 3b	Moderately to severely decreased
15 to 29	Stage 4	Severely decreased
< 15	Stage 5	Kidney failure

- Step 4 – Decide if CKD is present and whether stable or progressive

1. If GFR < 60, consider whether the diagnosis may be an acute kidney injury.
   - If there is a 25% reduction in a GFR from previously known baseline, seek urgent nephrology advice to decide whether an acute nephrology or general medicine assessment is required.
   - If it is uncertain how long the GFR has been low and the urine does not have any red or white cells, repeat blood and urine tests within a few days to ensure kidney function is not deteriorating quickly.
   - If unsure, contact the on-call nephrology registrar.
2. Make a diagnosis of CKD if ACR ≥ 30 or decreased kidney function (i.e., GFR < 60) for > 3 months.
3. Determine if CKD is progressive.
   - Progressive CKD is when GFR < 60 **and** GFR decreased ≥ 15 in previous 12 months or ACR > 250 (severe proteinuria).
   - These patients have a high risk of developing end-stage kidney disease which will need treatment with dialysis or a transplant. Request non-acute nephrology assessment.
   - Patients who are stable are at low risk of progression and can be managed in primary care.

- Step 5 – Additional tests

  - If CKD is confirmed, arrange:
    - Blood pressure measurement
    - CBC
    - If anaemia, consider iron tests, B12, and folate
    - Glucose, lipids, HbA1c
    - Calcium, albumin, serum protein electrophoresis (SPE) with immunoglobulin levels, and serum-free light chains (SFLC) to exclude multiple myeloma. In CKD, SFLC will be increased due to impaired excretion but the ratio will be normal.
    - See also multiple myeloma in the MGUS (Monoclonal Gammopathy) pathway.
  - Consider urinary tract ultrasound if CKD with:
    - GFR < 30
    - GFR < 45 with diabetes
    - GFR < 60 with evidence of progressive disease:
      - GFR decreased ≥ 15 in previous year, or
      - ACR > 250

Management

1. Look for red flags:
   - Consider acute kidney injury as this can be easily mistaken for chronic kidney disease.
   - Consider acute glomerulonephritis.
   - If any red flags or if uncertain how to proceed, seek nephrology advice advice to discuss management.
2. Consider any reversible causes of kidney disease e.g., hypovolaemia, sepsis, urinary tract obstruction, medications e.g., NSAIDs, ACE inhibitors, radiographic contrast material.
3. Decide whether kidney disease can be managed in general practice or whether specialist assessment is required.
   - Manage in general practice if these factors.

     Factors for managing CKD in general practice

     GFR is stable and:
     - in patients without diabetes – GFR > 30 without haematuria, without hypertension, or without albuminuria (i.e., ACR < 70).
     - in patients with diabetes – GFR > 45 without haematuria, without hypertension, or without albuminuria (i.e., ACR < 70).

   - Consider non-acute nephrology assessment or advice for CKD if **any** of these factors.

     Criteria for nephrology assessment or advice
     - Progressive CKD i.e., GFR < 60 **and** GFR decreased ≥ 15 in previous 12 months.
     - Low GFR (without diabetes): GFR < 30 (may not be needed if GFR stable, ACR < 70, and CV risk reduction achieved).
     - Low GFR (with diabetes): GFR < 45 (may not be needed if GFR stable, ACR < 70, and CV risk reduction achieved).
     - Intrinsic kidney disease – glomerulonephritis, polycystic kidney disease, interstitial kidney disease.

4. Review current medications and avoid nephrotoxic medications.

   Nephrotoxic drugs
   - NSAIDs and COX-2 inhibitors
   - Radiographic contrast agents
   - Aminoglycosides
   - Lithium
   - Calcineurin inhibitors e.g., cyclosporine and tacrolimus

5. In all patients, provide education and lifestyle modification.
6. Reduce blood pressure to achieve target blood pressure.
   - First-line therapy: start with an ACE inhibitor.
   - Second line – add in a calcium channel blocker.

7. Address cardiovascular risk factors:
   - Consider statin therapy.
   - If diabetes:
     - reduce HbA1c to individualised target. For more information, see Diabetes – Continuing Care.
     - in CKD stages 4 and 5 (GFR < 30) adjustment of hypoglycaemic agents may be required.
8. Ensure ongoing monitoring, as determined by the severity of CKD.

Ongoing monitoring frequency of CKD

CKD parameters*	Frequency of review	Clinical assessment	Laboratory assessment
GFR ≥ 60 with ACR 2.5/3.5 to 29 **or** GFR 45 to 59 with ACR < 2.5/3.5	Every 1 to 2 years	• blood pressure • weight • medications	• Urine ACR • Cr, electrolytes, urea • GFR • HbA1c if diabetes
GFR 30 to 59 with ACR 2.5/3.5 to 29 **or** GFR 30 to 44 with ACR < 2.5/3.5	Every 3 to 6 months	• blood pressure • weight • medications	• Urine ACR • Cr, electrolytes, urea • GFR • HbA1c if diabetes • CBC • Calcium and phosphate
ACR > 29 irrespective of GFR **or** GFR < 30 irrespective of ACR	Every 3 months	• blood pressure • weight • medications • oedema	• Urine ACR • Cr, electrolytes, urea • GFR • HbA1c if diabetes • CBC • Calcium and phosphate (3 to 6 monthly) • Other tests in collaboration with nephrology services

*GFR in mL/min/1.73 m^2, ACR values men/women

9. Consider future planning early, especially if severe disease (GFR < 30).

Future planning

Discussions about treatment with dialysis or kidney transplantation are best made in collaboration with a nephrologist.

If dialysis or kidney transplant is considered appropriate, this involves early patient engagement and coordination and collaboration with the nephrology team.

For some patients, dialysis or transplantation may not offer survival or quality of life benefits. These discussions may be part of an advance care plan.

10. If complications of advanced CKD or deteriorating renal function, arrange specialist assessment or advice as below.

Referral

- If any red flags, seek nephrology advice or request acute general medicine assessment.
- Request non-acute nephrology assessment if:
  - Uncontrolled hypertension associated with CKD (GFR < 60 and decreased ≥ 15 within the previous 12 months with or without ACR > 70).
  - Low GFR < 30 (without diabetes) (may not be needed if GFR stable, ACR < 70, and CV risk reduction achieved).
  - Low GFR < 45 (with diabetes) (may not be needed if GFR stable, ACR < 70, and CV risk reduction achieved).
  - Progressive chronic kidney disease (GFR < 60 **and** GFR decreased ≥ 15 in previous 12 months or ACR > 70).
- If patient has diabetes with poor glycaemic control, request non-acute diabetes assessment.

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Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Medical centre complaints policy (updated November 2016)

Purpose
This document outlines the processes involved in the reporting and management of a complaint received at the Practice. It is compatible with the Health and Disability Consumer complaints management requirements.

Scope
All staff

Definition
A consumer complaint is any expression of dissatisfaction received from a client, patient, visitor, family member, or a member of the community regarding an event that has occurred, a system or process within Practice name or a staff member.

Complaints may be either:

- Written - letter, email or fax
- Verbal - telephone or face-to-face

Accountability
- It is the responsibility of staff to ensure consumers are aware of how to make a written complaint.
- It is the responsibility of staff to ensure consumers are aware of these services.
- The complaints officer within

Verbal Complaints
- Verbal complaints are to be documented, either by the complainant or by the person receiving the complaint and to be managed in the same manner as a written complaint.
- An effort must be made to resolve the complaint immediately where possible. Often the staff member on the spot can handle verbal complaints.

Written Complaints
- All written complaints are to be forwarded to the Complaints / Privacy Officer.
- Written complaints or those written on consumer feedback forms are to be attached to the Incident Form for action. It is to be done by the end of the day on which the complaint is made.
- A consumer may instead, or also, involve the Health Advocates, and/or lay a complaint with the Health and Disability Commissioner and/or the Privacy Commissioner

Acknowledgement and Response Times

- All written complaints where the complainant wishes to identify themselves are to be acknowledged within 5 working days of receipt. If the complaint is resolved within 5 days, only a letter of response is required.
- Where appropriate, meetings with relevant staff may be arranged immediately on receipt of the complaint.
- All complaints will be investigated within 10 working days of acknowledgement to decide whether the complaint is justified / substantiated.
- If more than 10 working days is required to investigate the complaint, the complainant is notified that additional time is required. If the additional time is more than 20 working days, the complainant is informed and advised of the reasons why.
- The complainant will be updated on the progress of their complaint at intervals of not more than one month.

Staff Named in Complaint

- Staff named in or associated with a complaint are to be advised before any investigation commences and will be involved in the investigation.
- Staff may be asked to meet with the complainant to assist in complaint resolution.

Privacy Consent

- Complaints are confidential information and are to be stored securely at all times.
- All complaints correspondence is to be kept in a confidential file with the Privacy Officer.
- If a complaint is received from someone other than a client, and information in the response is related to the client's care and treatment, signed consent must be obtained from the client (or parent/guardian) before the outcome of the investigation can be released.
- If the complaint comes from a third party and the patient has died, the trustees and executors of the estate are to be asked for consent before the complaint is investigated. Evidence of the authenticity of the trustees or executor's consent is a copy of the Grant of Probate of the will of the deceased patient.

Complaints management process

- The complaint is received. If received in writing, forward to Complaints / Privacy Officer, if verbally taken, document details on the complaints form and forward to Complaints/Privacy Officer.
- Immediate action is taken to resolve the issue where possible.
- Confirm receipt at complaint with Complainant providing a timeframe for complaint resolution.
- Follow-up/investigate situation/issues and take appropriate action - investigation and action taken
- Where the complaint relates to a clinical issue/incident, an independent clinical review will be requested from the Chief Medical Advisor. (This is a comprehensive review and may take some time, please advise the complainant of the timeframe)
- If complaint/issue involves high-resolution factors, business partners may require a meeting to discuss issues and plan of action to respond to complainant and to address follow-up issues
- Once complaint/issues resolved, feedback to be given by Complaints / Privacy Officer to staff involved in the complaint.
- Complaints to be logged onto database

- All documentation relating to the complaint to be scanned together and filed by the Complaints / Privacy Officer. Do not file sensitive information in a public domain.
- Trends in complaints to be monitored by the Complaints / Privacy Officer
- Specific learning's from complaints to be discussed at quality or team meetings
- Any person who makes a complaint MUST be listened to with respect for their version of the incidents, their views, and feelings.
- Any staff member that is approached by a patient with a complaint must follow the correct procedure:
- Listen to the patient non-judgmentally.
- Refer the patient to Locality Manager (L.M.) if she is available.
- Make specific detailed notes of the patient's complaint in the "Incident Form". Include time, date and other pertinent information. Inform the patient about complaint procedure and please ensure you give the patient a copy of what has been written down.
- Inform the patient you will give the information to the Practice Manager & L.M. one of these people will be in contact with the patient to discuss the matter with them more fully or will send acknowledging letter to the complainant.
- If the complaint involves a staff member who is or is not present at the time of the complaint, the person taking details of the complaint MAY, at their discretion, inform that person about the complaint.
- Under no circumstances will the person taking details of the complaint divulge personal contact details (e.g. home phone number etc., of the person, complained about), to the person who has made a complaint.
- Do not enter into an argument with the patient over the facts of the complaint or try to justify any action. Ensure that the patient is heard, that they feel they are being taken seriously in their complaint and reassure them we will take action on their complaint by acknowledging it within 7 days.
- Ensure that any life-threatening issues are acted upon by a senior member of staff immediately.

Information should include:

- The patient's name.
- Significant other names.
- Date and time of call/complaint.
- Contact Phone number of patient calling.
- Situation/s or problems discussed and advice given.
- Legible Signature of Staff Member or name and initials with signature.

REMEMBER

- It is a patient's right to be informed that they may make a complaint to the Office of the Health & Disability Commissioner.
- The contact details and outline of procedures for HDC can be found on the poster on the Notice Board and leaflet in the waiting room.
- The information on patient advocate is also displayed within the practice

Response to the Complaint

- The response letter will outline the review of the complaint and any improvements that will be made as a result of this.

- The letter will offer the opportunity for a further discussion or family meeting if the complainant is dissatisfied with the response.

- A copy of the Health & Disability Code of Rights will be included with the final response letter.

- If a meeting is to be arranged, it is important that we ensure the complainant is aware of the health advocate service.

Complaints regarding a specific staff member

- It is expected the company will support staff when they receive a personal complaint about them. This support may be time off work, and/or counselling services. It is acknowledged that a personal complaint can have a profound effect on the confidence and self-esteem of the staff member concerned, whether it is a legitimate complaint or not. Evidence shows that whenever a patient has taken personal offence, the best approach is an apology by that staff member as soon as possible after the event. The staff member needs to understand that while the personal offence is never intentional, patients in vulnerable situations can easily misinterpret these intentions. The General Manager will contact the patient in the first instance, to request permission that the person concerned can contact them. Ideally, a speaker phone should be used during this conversation, with the discussion documented.

Suggestions

- The clinic would also like to welcome suggestions for improvement to the service by the public. It may include a discussion with a staff member who would then complete a suggestion form or the completion of a suggestion form by that person. The clinics have the suggestion boxes that patients can drop in their suggestions.

- The organisation has a legal, ethical and moral responsibility to accept and respond to consumer complaints related to its staff, services or providers. This policy identifies the processes and standards that apply in the management of the complaints process. The complaints policy reflects the requirements of Right 10 of the Code of Health and Disability Services Consumer's Rights 1996.

Also refer attached Flowchart

Note:

1. If the complainant is not satisfied, and on review, no further actions can be reasonably taken by the organisation to resolve the complaint, then the complainant must be advised of this in writing and be made aware of the avenues for further complaint. They should also receive copies of the HDC Code of patient Rights and Advocacy brochure as well as the details of professional registration bodies as appropriate. The file will then be closed.

2. The complaint will be recorded on the complaints register and may be referenced in the Significant Events Management section of the office meeting, maintaining confidentiality as required.