Northland District Health Board
Urologist, Dr A

A Report by the
Health and Disability Commissioner

(Case 17HDC02166)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by Northland District Health Board's (NDHB's) urology outpatient services. The services are provided by a specialist clinic under contract to NDHB. This case highlights the importance of having robust processes for sharing patient information, so that appropriate treatment can be provided.

2. A man was diagnosed with a high-grade bladder cancer and carcinoma in situ. This report discusses the factors that contributed to a delay in his diagnosis.

Findings

3. The Commissioner found that highly relevant information about the man's condition was not available to the urologist, owing to poor systems. The Commissioner found that the specialist clinic did not identify the man's status accurately when he changed from a public to a private patient, which led to confusion and miscommunication. Further, the man was left waiting in a car outside the Emergency Department in severe pain with no medical assistance. Accordingly, the Commissioner found NDHB in breach of Right 1(1) and Right 4(1) of the Code.

4. The Commissioner found that the urologist breached Right 4(1) of the Code by failing to obtain the man's referral letter and cytology results (at least after his first appointment), note the absence of urine cytology results in a letter to the man's GP, consider and rule out alternative explanations for the man's symptoms, and carry out appropriate investigations.

Recommendations

5. The Commissioner recommended that NDHB and the urologist apologise to the man and prepare a case study for the purpose of staff training, and that NDHB conduct communication training for Urology Service staff, review aspects of the Urology Service's referral triage system, audit the priority levels given to referrals, and develop a policy on the information that should be shared with patients about their public or private urology treatment options.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her husband, Mr B, by Dr A at a public hospital. The following issues were identified for investigation:

- *Whether Dr A provided Mr B with an appropriate standard of care between May 2016 and July 2016.*
- *Whether Northland District Health Board provided Mr B with an appropriate standard of care in 2016 and 2017.*

7. The parties directly involved in the investigation were:

Dr A	Provider/urologist
Mr B	Consumer
Mrs B	Complainant/consumer's wife
Dr C	Provider/urologist
Northland District Health Board (NDHB)	Provider

8. Further information was received from:

Dr D	Urologist
Dr E	Urologist

9. Also mentioned in this report:

Dr F	Urologist
Mr G	General manager

10. Independent expert advice was obtained from a urologist, Dr Anna Lawrence (Appendix A).

Information gathered during investigation

Background

11. In 2016, Mr B, then aged in his fifties, was experiencing pain when passing urine, and difficulty with bladder control, with a frequent urge to urinate and often needing to urinate several times throughout the night.

12. NDHB told HDC that for at least 15 years it has contracted a specialist clinic for the provision of its urology outpatient services, including consultations and a range of minor and diagnostic procedures. NDHB provides some medical personnel, and the specialist clinic provides the facility, equipment, management/administration, and some medical personnel.

Referral to Urology Clinic

13. On 11 February 2016, a general practitioner (GP) referred Mr B to the Urology Clinic at the public hospital. According to the referral letter, Mr B had lower urinary tract symptoms, the cause of which was not clear. The problems mentioned in the referral letter included prostatitis,[1] terminal dysuria,[2] microscopic haematuria,[3] and the presence of abnormal cells in the urine. It was also noted that he had a history of prostatitis and prostatism.[4]

[1] Inflammation of the prostate gland.
[2] Painful or difficult urination.
[3] Blood in the urine.
[4] A disorder resulting from obstruction of the bladder neck by an enlarged prostate gland.

14. The GP referral contained Mr B's past medical history, including that he was an ex-smoker,[5] and the copies of four urine cytology[6] reports, dated 27 January 2016, 29 January 2016, 3 February 2016, and 4 February 2016. All four urine cytology results were abnormal. All reports contain information pertaining to possible causes of the abnormal results, including possible neoplasia (cancer). No mid-stream urine results or urinary dipstick testing results were sent with the referral.

15. On 12 February 2016, Mr B's referral was triaged by urologist Dr F. The referral was coded as category 3 routine (which ordinarily means that a patient will be seen within four months).

16. The Clinical Director of the Urology Service at the public hospital, Dr C, told HDC that as the referral contained information about abnormal urine cytology, Mr B should have been ascribed a higher priority and seen within four weeks of the referral.

Consultation with Dr A — 23 May 2016

17. On 23 May 2016, Mr B presented to the specialist clinic as a public patient, and was seen by urologist Dr A.

18. Dr A did not have Mr B's letter of referral from his GP or the urine cytology results. Dr A said that had that information been available, he would have suggested further screening, beginning with further samples for cytology.

19. As to why Dr A was not aware of Mr B's urine cytology results at the time of his first appointment, Dr A said: "I cannot find out how it is that the information was not seen by me." He stated:

> "At that time, we received all information hard copy couriered to us from the DHB … this involved staff printing the material, putting the papers with other[s] to be sent, collecting up the bundle of printed copies and sending them by courier to our clinic. The packets would be opened, papers separated and on the appropriate day the patient information would be placed in a slot for me to collect for each patient who would normally be allocated a 15 minute appointment … I would read through the material put in the pigeon hole before calling the patient for the consultation. It was not unknown for the information to lack a GP referral letter for reasons including if it was not couriered, not prepared or had become separated from the other papers. Also at that time we could not easily access the electronic information such as laboratory reports unless we phoned for it. When aware previously that lab results were missing, I would try to hunt it down if alerted to or phone to get it."

20. Dr A said that the "routine" priority allocated fitted with the history Mr B gave to him at the time, so he was not alerted that he needed to "hunt out extra information".

[5] This is necessary information to determine the appropriate investigations for a working diagnosis of overactive bladder.

[6] Urine cytology is the examination of cells collected from a urine specimen. The test commonly checks for infection, inflammatory disease of the urinary tract, cancer, or precancerous conditions.

21. Dr A stated that Mr B gave a history of urinary outflow symptoms and some associated urinary frequency, which had improved significantly after his GP had prescribed an alpha blocker, doxazosin.[7] Mr B also reported having had some discomfort when voiding, but that problem had also apparently resolved with the medication.

22. According to Dr A, this picture fitted with the results of the urine flow test[8] and prostate examination undertaken at the appointment. However, Dr A suggested that Mr B have a flexible cystoscopy[9] as a screening investigation.

23. Dr A conducted an ultrasound scan. Mrs B told HDC that Dr A said that Mr B's bladder appeared to be normal.

24. Dr A sent a letter to the GP outlining his findings. The letter does not refer to the urine cytology results included with Mr B's referral, and does not mention whether Dr A undertook a urine cytology test when Mr B attended the specialist clinic.

Consultation with Dr A — 20 June 2016

25. Mr B saw Dr A again on 20 June 2016. Dr A still had not accessed Mr B's GP referral or the urine cytology results.

26. Mr B was still passing urine several times throughout the night, but this had improved since he had begun taking doxazosin. Dr A performed a flexible cystoscopy but was unable to find a cause for Mr B's symptoms. Dr A felt that Mr B's symptoms were attributable to a slightly enlarged prostate and that Mr B had bladder outflow obstruction. Dr A suggested that Mr B go home and "train the dog". Mr B understood this to mean that when he felt the urge to urinate, he should tell himself that he did not need to do so.

27. NDHB General Manager Mr G said that Dr A did not intend to be disrespectful, and was intending to provide advice about behaviour modification. With regard to the ultrasound scan conducted by Dr A on 23 May 2016, Mr G said that the views would have been suboptimal because fixation devices previously inserted when Mr B underwent a hernia repair would have cast a shadow on the images.

28. Mrs B told HDC that in the months following this appointment, Mr B attempted to manage his symptoms but, as he was unable to control his bladder, he missed work on occasions. Despite this, he was reluctant to return to the doctor. Eventually he returned to his GP to request an appointment with another urologist.

[7] Doxazosin is used to treat high blood pressure (hypertension). It is also used in men to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia (BPH)). Doxazosin does not shrink the prostate, but it works by relaxing the muscles in the prostate and part of the bladder. This helps to relieve symptoms of BPH such as difficulty in beginning the flow of urine, a weak stream, and the need to urinate frequently or urgently (including during the middle of the night).

[8] A flow test is an indicator of the health of the lower urinary tract, and is often used to determine whether there is a blockage to normal urine flow.

[9] A flexible cystoscopy is a procedure to check for any problems in the bladder using a flexible telescope (cystoscope).

Consultations with Dr C

29. On 9 March 2017, Mr B saw urologist Dr C at the specialist clinic as a private patient. By this time, Mr B had completed several courses of antibiotics, but his symptoms had not resolved. Mrs B told HDC that Mr B was having trouble working a full day, and was extremely uncomfortable. Dr C recommended a CT scan and blood tests.

30. Dr C said that he was not aware of the abnormal urine cytology results because they were not referred to in Dr A's reporting letter. Dr C said that had he been aware of the results at that time, he would have repeated the tests and arranged an urgent repeat flexible cystoscopy as well as a CT scan of the abdomen and a mid-stream urine sample.

31. On 10 March 2017, Dr C arranged for a mid-stream urine sample to be collected. Mr B saw Dr C again on 17 March 2017, and Mr B's CT scan was normal. Mrs B said that Dr C told Mr B: "[T]he good news is there isn't any bad news, you don't have bladder cancer."

32. Mr B's mid-stream urine test revealed leucocytes[10] but no bacteria. Dr C said that he prescribed Mr B more antibiotics in the belief that the urine test results indicated an infective problem within the urinary tract.

33. Dr C reported to a GP that he had arranged a follow-up appointment to see Mr B and repeat the flexible cystoscopy. Dr C said that this was indicated to ensure that nothing had been missed the first time, and to rule out changes since the first procedure.

34. On 27 March 2017, Mrs B telephoned the specialist clinic to explain that the antibiotics had made no difference to her husband's symptoms. Mrs B told HDC that her husband was "absolutely beside himself". She said that she spoke to the receptionist, who told her: "[Mr B] is in the public system, go and see your GP." She told the receptionist that her husband had seen Dr C privately, but again she was told to see the GP.

35. NDHB said that this was a consequence of the receptionist having misunderstood Mr B's status. Although he had seen Dr C privately, Dr C understood that Mr B wanted to have his second cystoscopy as a public patient, and to expedite this, Mr B needed to be re-referred by his GP. The DHB stated: "Nonetheless it is not acceptable for there to be a lack of civility in the communication with patients and family members." The DHB apologised for the lack of civility.

36. On 28 March 2017, Dr C telephoned Mr B to discuss his lower urinary tract problems. Dr C told HDC that he still believed that Mr B's symptoms could be due to infection, and considered trying Mr B on a different antibiotic. Dr C said that at that time he believed he would be seeing Mr B again for a follow-up flexible cystoscopy.

37. Mr B became increasingly distressed, so Mrs B attempted to contact Dr C at the specialist clinic. On 5 April 2017, she spoke to the Office Manager. The Office Manager believed that

[10] White blood cells (an increased amount of which may indicate an infection or obstruction in the urinary tract).

Mr B was being seen as a public patient, and offered him the next available appointment for a flexible cystoscopy, which was in eight weeks' time.

38. Mr B was frustrated by the Officer Manager's response. Having lost confidence in the specialist clinic and believing that something had been missed, Mr B returned to his GP to request a referral to a urologist in another centre.

Consultations with Dr E

39. On 8 May 2017, Mr B saw urologist Dr E. Dr E performed a flexible cystoscopy, which showed prominent and marked cystitis.[11] Dr E was concerned about the possibility of carcinoma in situ[12] and so arranged for a biopsy to be performed in two weeks' time.

40. On 22 May 2017, Mr B had a transurethral resection of a bladder tumour (TURBT). A biopsy was taken of the posterior wall of the bladder, which confirmed that Mr B had superficial high grade bladder cancer and carcinoma in situ.

41. On 1 June 2017, Dr E sent an urgent referral to the public hospital requesting that Mr B receive intravesical BCG treatment.[13]

Public hospital — June 2017

42. On 4 June 2017, Mr B attended the Emergency Department at the public hospital. He was experiencing a frequent urge to urinate, even though he was passing very little urine. He was given antibiotics and sent home.

43. On 6 June 2017, Mr B again attended the public hospital. Mrs B said that she left him in the car outside the ED because he had his penis in a bottle as it was dribbling blood. No staff member was available to see Mr B, so he waited in the car for a further 15 minutes, by which stage he was in unbearable pain. Mrs B again attempted to obtain assistance from ED staff, but again was told that no one was available to attend to Mr B.

44. Mrs B said that she was becoming increasingly frustrated and concerned about her husband, so she phoned Dr E. Dr E advised Mrs B to inform the ED staff that Mr B had bladder retention,[14] and that if a wheelchair was not brought out to the carpark, an ambulance would have to be called to attend to him. A member of the ED staff was then able to render assistance. Mr B was admitted to hospital and discharged on 9 June 2017.

[11] Inflammation of the bladder.

[12] "Carcinoma in situ" (CIS) refers to a cancer that is still confined to the cells in which it initially started and has not spread into any nearby tissue. Bladder CIS is "high grade", which means that the cells are very abnormal and are dividing rapidly. CIS has the potential to spread much more quickly than low grade tumours.

[13] BCG (bacillus Calmette-Guerin) is an intravesical immunotherapy using a bacteria of *Mycobacterium bovis* (bovine TB) that has been reduced to cause less harm to the body. "Intravesical" means that liquid drugs are put directly into the bladder through a catheter.

[14] A condition in which the bladder does not empty completely even when full and causing the urge to urinate.

45. The head of the ED subsequently told Mrs B by email on 18 July 2017 that this was an "unsatisfactory situation", and that he could not understand why a triage nurse or doctor did not attend Mr B while he was waiting for a bed to become available, at least to offer pain control and reassurance that steps were being taken. The head of the ED noted that it was not the role of the reception staff to deal with the situation; rather, the clinical staff should have assisted Mr B.

46. On 15 June 2017, Dr C wrote to Mr G requesting funding approval for Mr B's BCG treatment.

47. On 26 June 2017, Mr B had a follow-up appointment with Dr E. Mr B had not been contacted about the commencement of his BCG treatment. Mrs B said that at the suggestion of Dr E, she contacted the public hospital to follow up. She told HDC that she was advised that there was no record of Mr B requiring further treatment. Dr E contacted the hospital again to arrange for treatment.

48. Mr G stated:

> "I suspect that the confusion regarding the status of the BCG treatment arose because [Mrs B] spoke to a temporary hospital clerk who was covering the sick leave of the usual urology booking clerk … I am very sorry that the temporary member of staff was unable to satisfactorily deal with [Mrs B's] enquiry and I apologise for the distress caused by this."

49. Funding was approved on 27 June 2017, and Mr B commenced BCG treatment on 4 July 2017.

Further information — NDHB

50. On behalf of NDHB, Dr C provided the following explanation of the clinical context in which Mr B was being treated, and the rationale for the approach taken by Dr A when he first saw Mr B:

> "The nature of the symptoms were such that it was difficult to determine the exact cause of these problems … A superficial noninvasive cancerous bladder condition … can on some occasions cause the sorts of symptoms that [Mr B] had originally presented with. Although these symptoms are in fact associated with a number of other possible urological causes such as prostatic enlargement,[15] idiopathic detrusor (bladder) overactivity,[16] lesions outside the bladder, distal ureter stones,[17] inflammatory condition of the bladder[18] and the prostate.[19] The majority of patients

[15] Enlargement of the prostate gland, which can cause uncomfortable urinary symptoms.
[16] Overactive bladder occurs because the muscles of the bladder start to contract involuntarily even when the volume of urine in the bladder is low (and this creates the urgent need to urinate).
[17] Kidney stones that have become stuck in one or both ureters.
[18] This can stiffen the bladder wall and make it difficult for the bladder to expand fully.
[19] Swelling and inflammation of the prostate gland, which often causes painful or difficult urination.

> who are found to have CIS[20] present with microscopic or visible blood in the urine and on some occasions have lower urinary tract symptoms. The majority of patients with CIS will be found on cystoscopy to have small or large areas of abnormal epithelium (lining skin) in the bladder. However in some rare cases the bladder epithelium can look normal and is only found if there is a high index of suspicion and random bladder biopsies are taken. If there is not visible abnormality it is possible that the biopsies will also miss the areas of CIS."

51. Dr C further explained that given Mr B's symptoms at his first consultation, and the findings of no significant abnormality at the time of the flexible cystoscopy, it was likely that Mr B was suffering from detrusor[21] over-activity. Even so, Dr C acknowledged that bladder ultrasound scanning is not a highly accurate form of evaluation, but that it is useful in detecting large bladder masses, and is a useful, frequently used tool when trying to ascertain the cause of a patient's voiding[22] problems.

52. In relation to the appropriateness of the investigations that were performed when Mr B was first referred to the specialist clinic, Dr C advised that Mr B's GP had organised urine cytology tests, which revealed degenerative, atypical cells. According to Dr C, if Dr A had seen these results and been aware of Mr B's history of prostatitis, he would have arranged a flexible cystoscopy, which was an appropriate investigation in the circumstances. However, unfortunately, Dr A had not seen, and therefore had failed to note, the urine cytology results in the letter he sent to Mr B and Mr B's GP after the appointment.

53. Acknowledging Mr B's dissatisfaction with the treatment provided, Dr C advised:

> "We of course, are all very sorry that it did take a moderate amount of time for the cause of [Mr B's] lower urinary tract problems to be identified … We spend all of our lives trying to evaluate and treat people's health problems and we take our job very seriously. We always endeavour to do the best we can but we recognise at times that determining the cause of a patient's problems can be very difficult and it can take a prolonged period of time and a large number of investigations."

54. Dr C accepted that Mr B's carcinoma in situ could have been diagnosed at an earlier stage if more investigations had been performed. As a result of Mrs B's complaint, and the associated review of the care provided to Mr B, Dr C acknowledged the following issues as having been a problem in the referral, management, and investigation of Mr B's symptoms:

- Incorrect prioritisation of the first referral — the Urology Service will ensure that referrals are evaluated more carefully in future and that a re-evaluation by a senior nurse is conducted as a precautionary measure.

[20] Carcinoma in situ is a group of abnormal cells in the place where they first formed; they may also become cancerous and spread into normal tissue.
[21] A muscle that forms a layer of the wall of the bladder.
[22] When urine is released through the urethra.

- Dr A was not thorough enough when:
  - reading Mr B's referral letter
  - documenting relevant abnormalities in clinic notes and subsequent correspondence
  - evaluating and investigating Mr B's symptoms.
- Private patients should be made fully aware of their treatment options and whether their investigations are made publicly or privately.
- Clinic staff have completed training in regard to communication and managing conflict between both staff and patients and their relatives.
- A new urologist joined the specialist clinic in 2017, and it is hoped that this will alleviate workload issues that contributed to the problems with Mr B's treatment.
- It is hoped that the Urology Department will soon have access to the "Bladder Cx" test, which is helpful in evaluating patients with CIS in the bladder and other commonly seen types of bladder cancer.

Further information — Dr A

55. Dr A stated that given the implications for Mr B of what transpired, he and his colleagues at the specialist clinic reviewed Mr B's treatment and the problems associated with it. Dr A advised that the review prompted the following changes to prevent a similar problem occurring again:

- The triage system has been changed so that abnormal pathology results are transcribed at the initial triage so that they appear on the specialist clinic's medical records that are not linked to the main hospital records.
- Dr A insists on sighting the original GP referral before the first appointment with a new patient.
- The specialist clinic can now access referrals and other patient information electronically through the main hospital system, including pathology results (thereby avoiding the multiple steps and manual handling that was previously necessary for the relevant information to be available to practitioners in the specialist clinic).
- If no laboratory results are available to him, Dr A now asks patients whether they have had any recent tests, as an additional measure to protect against relevant information being missed.

56. Dr A also stated:

> "I was highly concerned to learn about what happened to [Mr B] and very sorry that this was one of a number of misadventures he experienced. I cannot apologise enough for what he has gone through. I take full responsibility for my part in the failure to know of and therefore recognise the underlying problem in this gentleman that resulted in a delay in his appropriate investigation and management which, as your expert witness has pointed out, includes a different set of investigations and screening the entire urinary tract.

> I deeply regret the problems [Mr B] has had, compounded by his most unpleasant complications after bladder biopsy … I have read the complaint from [Mrs B] and her concern that the previous response does not show accountability by me. The letter from your office to me was the first I knew of this particular concern. I can see though, that not hearing from me earlier has given the impression that I do not care whereas I do and deeply … For my part, what happened with [Mr B] continues to influence my practice on a daily basis."

Dr D

57. Dr A provided a report from urologist Dr D, in which Dr D opined that within the context in which Dr A was operating, his actions were, with the exception of one oversight, reasonable.

58. Dr D noted that Dr A failed to consider Mr B's referral from his GP and the results of his urine tests, as they were not available to Dr A at the time of Mr B's first specialist appointment. Dr D also noted that the intervening month between Mr B's first and second appointment provided ample opportunity for Dr A to obtain the relevant records, but this did not happen.

59. Dr D remarked that if Dr A had conducted a urine dipstick test early on, a different approach to Mr B's clinical management would have been likely.

60. In response, Dr A stated that the usual practice in the specialist clinic at the time was that the dipstick test was routinely carried out by nurses at the time of a flow test. Dr A believes that the specialist clinic's usual practice would have been carried out, and the most likely explanation is that the result was normal and so it was not documented. However, as Dr D noted, there is no documentation of a urine test having been carried out at the time of Mr B's second appointment either.

61. Dr D advised that although he could not discern any dismissal of Mr B's concerns or a failure by Dr A to take Mr B's condition seriously, "what transpired was not adequate management of an adult male with micro haematuria and four, unequivocally positive, urine cytology results".

62. Dr D concluded:

> "[W]hile there were matters that could have been managed better by [Dr A], which he acknowledges, the major shortcoming was a low initial priority ascribed to the case, no initial imaging or confirmatory tests prior to the first appointment, and, most importantly, the unavailability of the diagnostic and referral information at either clinical appointment. This subverted the process to a major degree."

Responses to provisional opinion

63. NDHB, Dr A, and Mrs B were given an opportunity to comment on relevant sections of the provisional opinion.

64. Mrs B told HDC that her goal when she made her complaint was to "make sure that nobody else had to endure what [her] husband had to endure". She commented that the way Mr B's illness was handled "made a difficult time just that much more difficult".

65. NDHB acknowledged that there were a number of failings in the care provided to Mr B throughout the course of his treatment with NDHB, and confirmed that it accepted the provisional findings and recommendations. NDHB told HDC that several of the provisional recommendations have already been addressed, and undertook to provide a detailed report addressing these.

66. Dr A reiterated his apology to Mr B and his acceptance of responsibility for his part in the failure to recognise Mr B's underlying problem. Dr A also submitted that he was placed in a situation of a faulty system that failed to gather, or if gathered, failed to place all information on file prior to a referral. He noted that there were links in the chain where information could and did go missing, and that this was a precondition for errors occurring. Dr A stated: "[T]his was not an error due to lack of knowledge or skill but due to lack of information in the context of poor system design."

Opinion: Northland District Health Board — breach

67. District health boards are responsible for the operation of the clinical services they provide. In addition, they have a responsibility for the actions of their staff, and an organisational duty to facilitate continuity of care. This includes ensuring that appropriate resources are available, and that all staff communicate effectively. It also requires that appropriate systems are in place for ensuring that patients are triaged appropriately, necessary tests (and repeat tests) are undertaken, and patients are treated with respect, even in circumstances in which workloads are high.

68. In this case, I am concerned about the triaging of Mr B's GP referral, the availability of documentation, the communication with Mr B, and the delay in diagnosing his carcinoma in situ. Overall I consider that Mr B's treatment was poor, and caused him considerable unnecessary distress.

Transfer of referral to Dr A

69. Mr B's referral letter from his GP and his urine cytology test results were sent to NDHB but were not made available to Dr A at the time of either of Mr B's appointments in 2016. Dr A said that had this information been available, he would have suggested further screening, beginning with further samples for urine cytology.

70. The system was that the DHB would courier hard copy information to the specialist clinic's urologists. On the day of a patient's appointment, the patient information would be placed in a slot for the clinician to collect. Dr A said that sometimes the information would not include the GP referral letter, for various reasons, such as it was not couriered, not

prepared, or had become separated from the other papers. At that time, the clinicians could not easily access the electronic information such as laboratory reports unless they telephoned and requested it.

71. I am critical that the system was ineffective and resulted in neither Mr B's GP referral letter nor the urine cytology results being available to Dr A. In my view, this information was crucial to Mr B's care, and the failure to provide this information affected the care that Dr A was able to provide.

Communication

72. The provision of both public and private treatment to Mr B at the specialist clinic resulted in confusion and Mr B being given inaccurate information.

73. Mr B initially presented to the specialist clinic as a public patient on 23 May 2016. On 9 March 2017, Mr B saw Dr C privately, and Mr B was told that he did not have bladder cancer. Dr C arranged for a repeat of the flexible cystoscopy and apparently concluded that Mr B wanted that done in the public system.

74. Consequently, on 27 March 2017 when Mr B was distressed by his symptoms and contacted the specialist clinic for assistance, he was not offered any, and was told to return to his GP. On 5 April, Mr B's condition had worsened, so his wife attempted to contact Dr C. She spoke to the Office Manager, who also believed that Mr B was being seen as a public patient and told him that the next appointment for a flexible cystoscopy was in eight weeks' time. In my view, that poor communication with Mr B by Clinic staff could have been avoided if Dr C had ascertained and recorded Mr B's status correctly.

75. It is understandable that Mr B was frustrated and lost confidence in the specialist clinic's service. As a result, he arranged for his GP to refer him to a urologist, Dr E, in another centre.

76. On 1 June 2017, Dr E sent an urgent referral to the public hospital requesting that Mr B receive BCG treatment for his bladder cancer. Although Dr C made a request to the DHB for funding for the BCG treatment, there was no communication with Mr B. Consequently, when Mr B next saw Dr E on 26 June, he advised Mr B to contact the public hospital to follow up. When Mrs B did so, she was told that there was no record of Mr B requiring further treatment. Dr E then contacted the hospital himself.

77. This was again very poor communication. NDHB said that it occurred because Mrs B spoke to a temporary hospital clerk who was covering for sick leave of the usual Urology booking clerk. In my view, this is not a satisfactory explanation. Mr B had recently been diagnosed with cancer and, understandably, wanted to get his treatment under way. The DHB should have had in place adequate systems to ensure that patients received accurate information even when a staff member was absent.

6 June 2017 ED presentation

78. On 6 June 2017, Mr B presented to the ED in a distressed condition. He was dribbling blood from his penis and experiencing severe pain. When Mrs B asked ED staff for

assistance as her husband was outside in the car, none was provided, so eventually she contacted Dr E for advice.

79. NDHB stated that this was an "unsatisfactory situation". I agree and find it incomprehensible that Mr B was left outside in his car without pain relief or reassurance whilst waiting for a bed to become available.

Conclusions

80. Mr B's treatment by NDHB was very poor. Highly relevant information about his condition that was included in the referral was not available to Dr A when he first saw Mr B, owing to poor systems.

81. The specialist clinic did not identify Mr B's status accurately when he changed from a public to a private patient, which resulted in confusion and miscommunication with Mr B. He was at times treated discourteously and given inaccurate information. In particular, he was left waiting in a car in severe pain with no medical assistance.

82. Accordingly, I find that NDHB breached Right 1(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[23] by failing to treat Mr B with respect, and Right 4(1) of the Code[24] by failing to provide services to Mr B with reasonable care and skill.

Other comment — triaging of initial GP referral

83. The referral from Mr B's GP contained his past medical history, which noted that he was an ex-smoker, as well as the results of four urine cytology tests. All four urine cytology results (taken during January and February 2016 by Mr B's GP) were abnormal, and all four reports noted cancer as a possible cause of the atypical test results. No objective information such as mid-stream urine results or urinary dipstick test results were sent with the referral.

84. On 12 February 2016, Dr F triaged the referral as routine, which meant that Mr B should have been seen within four months. My expert advisor, Urologist Dr Anna Lawrence, advised that this would be seen as acceptable by urologists, as triage categories are well debated when developed at each DHB.

85. However, Dr Lawrence noted that Mr B's risk had increased given the abnormal urine cytology and Mr B's history of smoking, and that in future the DHB could consider including those factors when triaging patients to increase their triage priority. I note that Dr C shares this view, and changes have been made to the DHB's triage system accordingly. I commend the DHB's improvements in this regard.

[23] Right 1(1) states: "Every consumer has the right to be treated with respect."
[24] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Opinion: Dr A — breach

86. Dr A did not have available the referral letter from Mr B's GP or Mr B's urine cytology results. However, given Mr B's history and presenting symptoms, Dr A should have conducted a more thorough assessment of Mr B.

Failure to seek GP referral letter and cytology results

87. Mr B's referral and cytology results should have been available to Dr A before Mr B's first appointment. Dr A said that the priority "routine" fitted with the history Mr B gave to him, so he was not alerted that he needed to look for more information. I note that Dr A attributes the failure to access and consider this information to the Urology Clinic system for receiving such information in place at the time.

88. However, in my view, Dr A should have checked that he had the necessary information available prior to the appointment, especially as it was not unusual for documentation to be missing. Dr Lawrence advised that the standard of practice in these circumstances would be to request the referral and associated information to be available at the time of the consultation. I am critical that Dr A did not take steps to access Mr B's urine cytology before Mr B's first appointment, or at the very least after the first appointment, so that Dr A could then take it into account when Mr B had his second appointment.

89. Furthermore, Dr Lawrence advised that urine cytology is an essential investigation finding that should be mentioned in reporting back to a patient's GP. Dr Lawrence noted:

> "[T]he lack of correspondence regarding the urine cytology from [Dr A] to the GP means that the abnormalities remain unaddressed, and implies that they were not considered in the planning of investigations and in the differentiate of different possible causes of [Mr B's] symptoms."

90. Dr Lawrence considers that the failure to mention urine cytology and address abnormalities in any clinical correspondence would not be viewed as acceptable by her peers.

91. Dr Lawrence advised that these failures are a departure from an acceptable standard. I agree, and I am critical that Dr A was not more thorough in obtaining the information necessary to provide Mr B with appropriate treatment.

Reasonableness of diagnosis of new onset irritable bladder

92. Dr Lawrence advised that urinary frequency and the urge to urinate during the night are associated with an overactive/irritable bladder. However, pain when urinating and a slow flow are not classically associated with an overactive bladder. Dr Lawrence further advised that for the management of adults with an overactive bladder, a clear understanding of the lower urinary tract symptoms must be established, including the rapidity of onset, duration, and, in particular, the severity of the symptoms. Dr Lawrence noted:

> "The history recorded on 23/05/2016 and 20/06/2016 does not discuss the symptoms of urgency, frequency and incontinence. Nor is there discussion of [Mr B's] risk factors

for urothelial cancer, smoking history, haematuria, or previous history of prostatitis. All of which is pertinent information to determine the appropriate investigations for a working diagnosis of overactive bladder, but also to allow other differentiate diagnosis to be considered."

93. It is of concern that Mr B's symptoms relating to his lower urinary tract were not investigated adequately. I agree with Dr Lawrence that Dr A should have been more thorough in relation to Mr B's risk of urothelial cancer, and I am critical that this resulted in a failure to investigate the working diagnosis of an overactive bladder appropriately, and allow for differential diagnoses.

Failure to carry out urine testing

94. Dr Lawrence advised that the required standard of care for the investigation of an irritable/overactive bladder is a negative urine test, a bladder diary consistent with an overactive bladder, and a minimal amount of post-void residual urine.

95. Dr A completed only a post-void residual test, which Dr Lawrence considers to be a moderate departure from standard care. I agree with Dr Lawrence, and I am critical that Dr A did not investigate Mr B's symptoms adequately. The failure to ascertain Mr B's history, as well as carry out a negative urine test and obtain a bladder diary, contributed to the delay in Mr B being correctly diagnosed and treated.

Discharge in June 2016 without formal follow-up or screening for cancer

96. As noted, given Mr B's initial presentation, a complete set of investigations into Mr B's urinary symptoms should have been carried out. Dr Lawrence has identified that Dr A did not obtain any imaging of Mr B's upper urinary tract, and did not fully investigate the microscopic haematuria. According to Dr Lawrence, to have discharged Mr B without obtaining the necessary imaging or investigating the microscopic haematuria is a departure from accepted practice.

97. I acknowledge that Dr A attributes these failures to the fact that he did not have access to Mr B's referral letter or the urine cytology results. However, as Dr Lawrence explained, if the necessary referral information and test results were not available initially, they should (at the very least) have been followed up and made available for the second consultation. There is no indication that Dr A took any steps to obtain this information, thereby missing important details. Furthermore, Dr Lawrence is of the view that the system error does not mitigate the fact that Dr A's initial assessment was incomplete.

98. Despite the system failures, the onus was on Dr A to be more diligent in his assessment of Mr B, and to investigate his symptoms.

Conclusion

99. I consider that Dr A failed to provide Mr B's services with reasonable care and skill by failing to:

a) Obtain Mr B's referral letter and cytology results, at least after Mr B's first appointment;

b) Note the absence of urine cytology results in his letter to Mr B's GP;

c) Consider and rule out alternative explanations for Mr B's symptoms; and

d) Carry out appropriate investigations, including imaging and urine analysis.

100. I consider that Dr A failed to assess Mr B systematically and comprehensively. Accordingly, I find that Dr A breached Right 4(1) of the Code by failing to provide services to Mr B with reasonable care and skill.

Recommendations

101. I recommend that within three months of the date of this report, NDHB carry out the following recommendations and report back to HDC:

a) Prepare an anonymised case study, based on Mr B's case, for the purpose of staff training, and arrange for the training to take place.

b) Conduct ongoing refresher training for staff of the Urology Service with regard to communication and managing conflict between staff, and patients and their relatives.

c) Consider whether a re-evaluation by a senior nurse of triaging of referrals is required as a precautionary measure.

d) Review the NDHB Urology triaging codes/categories in light of the issues in this report.

e) Conduct an audit of the Urology Service to identify whether the priority level given to referrals correlates with the test results available at the time of referral.

f) Incorporate into the triage system the requirement for upper tract radiology to be obtained and reviewed for patients with micro haematuria.

g) Develop a policy on the information to be provided to private patients regarding their treatment options and whether their investigations are to be made publicly or privately.

102. I recommend that within three months of the date of this report, Dr A prepare an anonymised case study for sharing with colleagues, for training purposes.

103. I recommend that both NDHB and Dr A each separately provide a written apology to Mr B for their breaches of the Code. The apologies are to be sent to HDC within three weeks of the date of this report, for forwarding to Mr B.

Follow-up actions

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

105. A copy of this report with details identifying the parties removed, except NDHB and the expert who advised on this case, will be sent to the Urological Society of Australia and New Zealand, the Royal Australasian College of Surgeons, the Central Technical Advisory Service, ACC, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent urology advice to the Commissioner

The following expert advice was obtained from a urologist, Dr Anna Lawrence:

"I, Anna M Lawrence have been asked to provide an opinion to the Commissioner on case number C17HDC02166. I have read, and I agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a NZ trained Urologist, MBChB, FRACS (Uro) who works in the CMDHB, and ADHB Urology departments. I see male and female patients and specialise in complex functional urology, which is the sub-speciality of difficult voiding (going to the toilet to urinate) dysfunction in patients with and without functional disorders such as spina bifida, Spinal cord injuries, urethral disorders and pelvic floor disorders.

I have been asked to review the supplied documentation regarding case number C17HDC02166 and advise whether I consider the care provided to [Mr B] by [Dr A] and [Dr C] was reasonable in the circumstances and why. The specific questions asked and to be addressed are below in bold, with my opinion below the question.

The documents provided and reviewed

1. Letter of complaint [date]
2. Northland DHB response 12.01.2018
3. Clinical Records from Northland DHB covering the period 22 May 2017 to June 2017
4. [The specialist clinic's] response 17th January 2018
5. Clinical records from [the specialist clinic] covering the period September 2016–September 2017
6. Clinical record from [Dr E] dated 8th of May 2017
7. Complainant feedback on response dated 23rd May 2018
8. Northland DHB Urology Department Triage guidelines/categories

I have summarised the relevant clinical history under each question before answering these questions.

1. Whether the routine priority given to the initial GP referral was appropriate given the clinical picture described the presence of atypical cells on three consecutive urine cytology results.

[Mr B] was referred by his GP on the 11th February 2016. The reason for the referral was prostatitis, terminal dysuria, microscopic haematuria and abnormal cells.

The GP referral contained [Mr B's] past medical history, including [Mr B] being an ex-smoker and the copies of four urine cytology reports, dated 4th February 2016, 3rd February 2016, 29th January 2016 and 27th January 2016. All four urine cytology was abnormal. All reports contain information pertaining to possible causes of the atypia in the urine samples including possible neoplasia (cancer). No objective information (no

mid-stream urine results or urinary dipstix testing results) pertaining to the microscopic haematuria was sent with the referral.

This was triaged by [Dr F], on the 12th of February 2016 as routine, with a timeframe as 3H. He also noted the patient was for a flow and flexi on the triage internal use only notes. Referencing the Northland DHB triaging categories [Mr B's] referral falls into the triage category 3, to be seen within 4 months. With this guideline for triaging at the Northland DHB, [Mr B] was seen within their department's triage category time frames and within Ministry of Health guidelines of all patients being seen within 4 months. This would be seen as acceptable by Urologists as triage categories are well debated when developed at each DHB.

Despite this, the presence of abnormal urine cytology, with a history of smoking increases the relative risk of a patient having a urothelial (urinary tract lining cells, they line all the urinary tract including kidney, bladder ureters and urethra) abnormality such as cancer. As such it would be appropriate to consider these factors, when triaging patients in the future, and consider increasing their triage priority to a higher priority. [Dr C] has mentioned in his letter of reply on 17th January 2018, that the Northland Urology Department is obtaining the urine test 'Bladder Cx'; this will assist the department in improving the triaging process especially in the presence of abnormal urine cytology.

2. [Dr A's] management of [Mr B] in May and June 2016 including

a. **Reasonableness of diagnosis of new onset irritable bladder in a [man in his fifties]**
b. **failure to mention urine cytology results in any clinical correspondence**
c. **decision to discharge [Mr B] in June 2016 following normal cystoscopy, without formal follow up (scheduled repeat cystoscopy) or consideration of CTU**
d. **any other comments**

[Mr B] was reviewed on the 23rd May 2016 by [Dr A]. At this time, he described [Mr B's] symptoms of slow flow, significant urinary frequency and at intervals some urethral pain with voiding for quite some time. It appears he was commenced on Doxazosin prior to this appointment, with an improvement in his flow, with less day time frequency but still nocturia 3–4 times (voiding during sleeping hours).

A urinary flow was completed with voided volume noted (370mls), curve flow noted, and peak flow of 22mls/sec. Digital rectal examination reveals a small firm prostate.

[Dr A] then comments that he believes that [Mr B] has genuine urinary outflow obstruction relieved by alpha blocker. He then comments he has some irritative symptoms in the past and makes arrangements for a flexible cystoscopy.

There is no reference to the urine cytology completed in January and February, 2016. There is no reference to planning any urinary tract imaging, nor any further urine samples.

A. Reasonableness of diagnosis of new onset irritable bladder in a man in his fifties.

From the history taken it is unclear how long [Mr B's] symptoms have been present. The only documentation of length of time was the comment 'quite some time' regarding a slow flow and significant urinary frequency.

The symptoms of urinary frequency and nocturia (night time voiding) are in keeping with an overactive bladder (previously called irritable bladder). However, pain with voiding, and a slow flow are not classically associated with an overactive bladder.

The history taken is not complete enough to make a confirmed diagnosis of irritative bladder. Current standards for NZ practices from the 2016 Conjoint Urological Society of Australia and New Zealand (USANZ) and Urogynaecological Society of Australasia (UGSA) guidelines on the management of adult non-neurogenic (patients without a defined neurological injury or illness such as a Spinal cord injury) overactive bladder states 'a clear understanding of the LUTS (lower urinary tract symptoms) must be established, including the rapidity of onset, duration and, in particular, the severity of the symptoms'. The history recorded on the 23/05/2016 and 20/06/2016 does not discuss the symptoms of urgency, frequency, and incontinence. Nor is there a discussion of his risk factors for urothelial cancer, smoking history, haematuria or previous history of prostatitis. All of which is pertinent information to determine the appropriate investigations for a working diagnosis of overactive bladder, but also to allow other differentiate diagnosis to be considered.

Current standard of care, as per the above group, for the investigation of irritable/ overactive bladder are a negative urine test, a bladder diary consistent for overactive bladder, and minimal post void residual. Only a post void residual was completed.

As the history that was obtained was not in keeping with the guidelines of the USANZ and UGSA group and only one investigation was completed (post void residual), I would view this as a moderate departure from acceptable practice as the history obtained from [Mr B] was not detailed enough to ensure all possible differential diagnoses were considered in the investigations and work up of [Mr B's] symptoms.

B. Failure to mention urine cytology results in any clinical correspondence

[Dr A's] correspondence to the GP on the 23rd May 2017 and the 20th June 2017 discusses the investigation findings of the PSA, flow test, his DRE, and his flexible cystoscopy findings. The referral urine cytology was not mentioned.

All investigations pertaining to the patient's current referral and symptoms, and investigations involved in the diagnostic work up of a patient, should be mentioned in correspondence. Both negative and positive findings should be mentioned to demonstrate diagnostic process (how the diagnosis was concluded).

The lack of correspondence regarding the urine cytology from [Dr A] to the GP, means that the abnormalities remained unaddressed, and implies that they were not considered in the planning of investigations and in the differentiate of different possible causes of [Mr B's] symptoms. This failure to mention urine cytology and address these abnormalities in any clinical correspondence would not be viewed as acceptable by our Urological peers and as [Dr C] has mentioned in his letter 17th January 2018, the majority of Urologists would have investigated these abnormalities further so as to determine the source; I therefore believe this is a moderate departure from acceptable care.

C. Decision to discharge [Mr B] in June 2016 following normal cystoscopy, without formal follow up (scheduled repeat cystoscopy) or consideration of CTU

[Mr B's] initial referral was for microscopic haematuria (blood in the urine), and abnormal cells in his urine. No investigations were undertaken by [Dr A] to prove or disprove the presence of blood in [Mr B's] urine such as repeat urine testing. As such a complete set of investigations should have been completed for microscopic haematuria.

The American Urology Association, European Urology Association and Regional referral pathways dictate guidelines for investigation of microscopic haematuria (blood in the urine). These guidelines include obtaining a history of the patient's risk factors for urothelial cancer (bladder cancer) such as smoking, a flexible cystoscopy, and upper urinary tract radiological imaging such as an Ultrasound (USS) or CT scan of the kidneys.

[Mr B's] upper urinary tract was not imaged either by USS or CT scan under [Dr A's] care, which is a severe deviation from the standard of care for a presentation of microscopic haematuria. To discharge [Mr B] without completion of the standard of care for investigation of microscopic haematuria is a serious departure from acceptable practice.

D. Any other comments:

[Dr A's] failure to address the abnormalities in the urine cytology sample, and failure to complete a standard work up for haematuria is a deviation from acceptable practice.

Abnormal urine cytology needs to be investigated to determine the source of the abnormal cells. This is normally completed with a flexible cystoscopy, and upper urinary tract radiological imaging, such as an Ultrasound or CT Scan, and or further urine sampling, or general anaesthetic cystoscopy with biopsies of the bladder.

[Dr A] completed a flexible cystoscopy for [Mr B], however it is not clear that this was initiated because of the abnormal urine cytology as he mentions in his letter (23rd May 2017) 'because he has had some irritative symptoms in the past we have made arrangements for him to come for a flexible cystoscopy'. He also mentions that should

his symptoms remain resolved he can cancel the appointment. This would not be an appropriate management step in the investigation of abnormal urine cytology.

[Mr B] should have been investigated further to determine the source of the abnormal urine cytology or as a minimum been asked to repeat when feeling improved to determine if the abnormalities remained. This should have been clearly documented in the letters sent to the GP.

[Mr B] should have been directed to complete upper urinary tract imaging/ radiological investigations (USS or CT scan) as part of the standard of care for investigation of microscopic haematuria.

Both the microscopic haematuria and abnormal urine cytology remained incompletely investigated when [Mr B] was discharged back to his GP. This is not acceptable care and would be considered a serious deviation of practice.

In [Dr C's] letter, 17th of January 2018, he has addressed the concerns about the lack of radiological investigations and has said that all patients with abnormal cytology will have the appropriate radiological investigations completed in the future. This is an adequate remedial step to ensure acceptable delivery of care going forward.

3. [Dr C's] management of [Mr B] in March 2017.

A. Should [Dr C] have established whether or not [Mr B] had previously had urine cytology undertaken, or have repeated it himself to assist in prioritising repeat cystoscopy?

B. Given [Mr B's] clinical presentation and noting the MSU result of 17 March 2017 (negative culture, >1000RBC), was it reasonable to accept a repeat cystoscopy date of two months from time of referral?

[Mr B] was reviewed on the 9th of March 2017 by [Dr C] in his private rooms.

On this occasion the referral sent from [a GP] dated 2/2/2017 was 'recurrent prolonged episodes of dysuria and frequency ? cause'. Information provided discussed '? prostatitis — dysuria, frequency, nocturia, pain in rectum on passing stools. At that time had a negative dipstix'. Previous abnormal urine results were not sent with this referral or attached to the referral.

[Dr C] noted in his consultation that [Mr B] had possible prostatitis, and was treated with 4 weeks of antibiotics, which brought about some relief of his symptoms, but they (the symptoms) tended to recur. He describes [Mr B's] symptoms of frequency, urgency urge incontinence and pain with voiding. He comments on the blood testing in September of 2016, but no comment on the previous urine cytology.

[Dr C's] examination findings at the time were unremarkable except the finding of generalised tenderness of the prostate but no more tender than the rest of the pelvic area.

He describes [Mr B's] symptoms as intermittent and unusual and discusses possible other pathologies in the pelvis or ureter as the cause. He ordered a repeat set of blood tests and a CT scan as diagnostic investigations for the possible cause and asked for [Mr B] to return for follow up of these investigations.

A. Should [Dr C] have established whether or not [Mr B] had previously had urine cytology undertaken, or have repeated it himself to assist in prioritising repeat cystoscopy?

The previous urine cytology was not mentioned in the correspondence from the GP (dated 2.2.2017). Nor was it mentioned in previous correspondence by [Dr A]. This means that [Dr C] was unlikely to have been aware of the urine cytology.

[Dr C] was investigating [Mr B] for infective causes of his urinary symptoms and was concerned with possible ureteric or other pelvic pathologies causing the symptoms. Urine cytology is not a standard investigation in the work up of urinary symptoms if you believe them to be infective.

Urine cytology is a poorly sensitive test but highly specific. This means it is not a reliable witness for determining the prioritisation/triaging for repeat cystoscopy unless a patient has a known high grade urothelial cancer especially when the working diagnosis is an infective cause of the symptoms. The repeat mid-stream urines revealing ongoing haematuria and sterile pyuria I believe were appropriate investigations at this time by [Dr C] and prompted the appropriate repeat cystoscopy.

B. Given [Mr B's] clinical presentation and noting the MSU result of 17 March 2017 (negative culture, >1000RBC), was it reasonable to accept a repeat cystoscopy date of two months from time of referral?

[Mr B] was reviewed by [Dr C] on the 17th of March 2017. The MSU from the 10.3.2017 that was reviewed revealed gross leucocytes (white blood cells), and no bacterial growth (sterile pyuria). At this time, it appears that [Dr C's] working diagnosis was of a urinary infection of uncertain origin, as an antibiotic, cefaclor, was prescribed. [Mr B] was sent for further urine testing at this time, and a follow up flexible cystoscopy was arranged.

The repeat urine sample 17.3.2017 had increased number of RBC (red blood cells) and fewer leucocytes but still persistence in abnormal numbers.

Given [Mr B's] on going pain with voiding, and persistent microscopic haematuria and persistent sterile pyuria, a semi urgent flexible cystoscopy should be considered, which [Dr C] did organise. A semi urgent time-frame is within 4–8 weeks within the DHB system. [Mr B] was booked for a flexible cystoscopy in May, which would have fallen within this period.

4. Adequacy of remedial measures outlined in the provider response

I believe that the remedial measures go some way to address the lack of completion in the initial evaluation. A triaging system that orders upper tract radiology when the referral is with microscopic haematuria may already be in place at Northland DHB (there is no documentation mentioning this), but if not, it should be installed. As standard investigation of haematuria all DHBs currently ensure the patient has completed their radiological imaging prior to outpatient consultation. This may have prompted [Dr A] to review the referral further if completed prior to outpatients and as part of standard triaging for haematuria.

If introduced Bladder CX will allow Northland DHB to triage and prioritise with more certainty those that need urgent flexible cystoscopies and those that can wait or defer. I think it would be of gross benefit if introduced given the access issues for public procedural clinics. If not introduced then a triaging based on risk factors, presentation symptoms should be developed to ensure no unnecessary waiting."

Addendum: 28th March 2019

"I have reviewed

1. My initial report dated 13/7/2018, REF: C17HDC02166
2. [Dr A's] response 21 November 2018
3. Letter of complaint [date]
4. Northland DHB response 12.01.2018
5. Clinical Records from Northland DHB covering the period 22 May 2017 to June 2017
6. [The specialist clinic's] response 17th January 2018
7. Clinical records from [the specialist clinic] covering the period September 2016–September 2017
8. Clinical record from [Dr E] dated 8th of May 2017
9. Complainant feedback on response dated 23rd May 2018
10. Northland DHB Urology Department Triage guidelines/categories

I believe that with the steps that [the specialist clinic] has in place as listed in [Dr A's] response, 21.11.2018:

1. abnormal cytology being transcribed to the triage
2. ensuring referral are available prior to review the patient
3. access to electronic medical records

this will help mitigate any administration steps that can lead to clinical misinformation, misdiagnosis and decrease the risk of further vital clinical information being overlooked.

The use of Bladder Cx in triaging clinical need with regards to new referrals from the GP will help address the scarcity of access to urology services in Northland.

It is unclear if a triaging system that orders upper tract radiology when the referral is received with microscopic haematuria is in place, or is intended to be introduced. If in place then this is in keeping with the majority of urology department DHBs in NZ to allow faster assessment and a prompt to doctor to review all the information available or request further pertinent investigations.

My previous report comments stand with regards to previous questions I was asked to address."

Addendum 28th July 2019

"I have reviewed

1. My initial report dated 13/7/2018, REF: C17HDC02166
2. [Dr D] independently commissioned report
3. My second report: Regarding C17HDC02166
4. [Dr A's] response 21 November 2018

I believe the steps that Northland Health has introduced to address the systems errors that caused the referral and its vital information to not be present at the time of [Dr A's] assessment of [Mr B] should align Northland Urology practice with other DHB first specialist appointments policies.

The lack of access to the referral and urine cytology at the initial consultation is a significant systems error, however, [Dr A] fails to mention that he has not reviewed or received the referral letter in his correspondence to the GP. I believe that recording this at the time of the initial presentation would have alerted the GP that essential information pertaining to the reason for the referral for this patient had not been appreciated or available. It would also explain why the abnormal cytology was not addressed in the initial consultation. Standard of practice would be to request the referral and associated data to be available at the time of the consultation, and if not available to request it for review at follow up or re-book patient at a later date where all information is available to the Specialist to ensure no details are missed. These steps do not appear to have been taken or put in place for [Mr B's] care.

The system error does not mitigate that the initial assessment was incomplete as per current guidelines, both Australasian and European, for non-neurogenic lower urinary tract symptoms and missed essential details such as [Mr B's] smoking history which should have alerted [Dr A] to the need to think of urothelial abnormalities of the bladder and as such complete appropriate workup. [Dr A] has commented that [Mr B] has had previous irritative symptoms, but it is not clear how he came to this conclusion as the history including important negatives is not recorded in the documentation. Following this, he has not ordered any urine testing, which is standard of care in the initial assessment of lower urinary tract symptoms especially in an 'irritative bladder' which may have alerted him to the abnormality of haematuria, and prompted imaging of the upper urinary tract, and possibly an earlier cystoscopy. I have discussed this with Colleagues, and they agree that the lack of a complete history and urine testing is a deviation of standard practice."