Dr C, General Practitioner

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 13HDC00599)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. On 16 November 2009, Mrs A (aged 57 years) attended a consultation with Dr C at a medical centre. Mrs A had been diagnosed and treated for breast cancer in 2003. Mrs A told Dr C that she had been experiencing pain and reduced movement in her left shoulder. Dr C referred Mrs A for an X-ray and ultrasound.

2. On 19 November 2009, Mrs A underwent an X-ray and ultrasound of her left shoulder.

3. On 23 November 2009, Dr C received and reviewed Mrs A's imaging report in which the specialist radiologist, Dr D, commented that a full thickness tear of the tendon was evident and the appearance was highly suggestive of metastasis. A bone scan and review by an oncologist was strongly recommended.

4. After reviewing the imaging report on 23 November 2009, Dr C arranged to see Mrs A. Mrs A attended a consultation with Dr C later that day, but Dr C did not discuss with her the possibility of metastasis referred to in the radiologist's report.

5. On 23 January 2010, Dr C referred Mrs A to an orthopaedic surgeon for a review of her left shoulder problems. The referral letter made no mention of the possibility of a bony metastasis being present, as stated in the imaging report, and referred to Mrs A's previous breast cancer only briefly.

6. Orthopaedic surgeon, Dr B, subsequently diagnosed Mrs A as having a metastatic lesion in her left shoulder, likely of breast origin given her medical history.

Findings

7. Dr C did not arrange adequate timely follow-up in response to the imaging report received on 23 November 2009. Accordingly, Dr C failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) [1] of the Code of Health and Disability Services Consumers' Rights 1996 (the Code).

8. Dr C failed to discuss the scan results with Mrs A and the possibility of metastatic disease as indicated in the imaging results. This is information that a reasonable consumer in Mrs A's circumstances would expect to receive. Dr C breached Right 6(1)[2] of the Code.

9. The referral letter Dr C sent was not of an appropriate standard, and Dr C breached Right 4(2)[3] of the Code.

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive."
[3] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards."

10. Adverse comment is made about the company which owns and operates the medical centre.

11. Dr C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

Complaint and investigation

12. The Commissioner received a complaint in 2013 from Mrs A about the services provided to her by Dr C at a medical centre. The following issues were identified for investigation:

- *Whether Dr C provided Mrs A with an appropriate standard of care from 2009 to 2010.*
- *Whether the medical centre provided Mrs A with an appropriate standard of care from 2009 to 2010.*

13. An investigation was commenced on 29 October 2013.

14. The parties directly involved in the investigation were:

Mrs A (dec)	Consumer
Dr C	Provider/General Practitioner
The medical centre	Provider

15. Information was reviewed from Mrs A, orthopaedic surgeon Dr B, and Dr C.

Also mentioned in this report: radiologist Dr D.

16. Expert clinical advice was obtained from general practitioner Dr David Maplesden (**Appendix A**).

Information gathered during investigation

17. Dr C advised HDC that he has worked as a general practitioner (GP) for approximately 31 years.[4] Dr C practises from his rooms at the medical centre, which is owned and operated by a company.

[4] Dr C is a vocationally registered general practitioner, and has been registered with the Medical Council of New Zealand for over 40 years.

18. In 2009, Mrs A (aged 57 years) had been Dr C's patient for over 20 years. Mrs A's medical history included a partial mastectomy for cancer in her left breast in 2003, and treatment with tamoxifen.[5]

Chronology of events

Consultation 16 November 2009

19. On 16 November 2009, Mrs A attended a consultation with Dr C at the medical centre. Mrs A told Dr C that she had been experiencing pain and reduced movement in her left shoulder since she had injured herself while playing sport earlier that year.

20. Dr C examined Mrs A and diagnosed a rotator cuff injury with a partial or complete tear of a tendon. He prescribed non-steroidal anti-inflammatory medication (Synflex) to relieve the pain and referred her for an X-ray and ultrasound.

21. On 19 November 2009, Mrs A underwent an X-ray and ultrasound of her left shoulder.

Imaging report

22. On 23 November 2009, Dr C received Mrs A's imaging report in which the radiologist, Dr D, commented that a full thickness tear of the tendon was evident. Dr D also made the following comment:

> "Patient was in a lot of pain … I note that the patient has a history of being treated for breast malignancy. 'Moth-eaten' osteolytic changes are evident in proximal humeral shaft and extending through to the surgical neck of humerus, with bony erosion at its proximal medial margin. Appearances would be highly suggestive of metastasis. Bone scan and Oncologist specialist review is strongly recommended."

23. Dr C told HDC:

> "I reviewed [Mrs A's] imaging report in my computer records and concurred … that as well as a rotator cuff tear there was the possibility of a metastatic abnormality in her L) humerus from her previous breast cancer."

24. Dr C said that following his review of the abnormal report, he intended to action it in relation to the torn tendon and the possibility of bony metastases.[6] He recorded in the medical centre's electronic patient management system (PMS): "[T]orn tendon with changes of possible 2* spread." Dr C then arranged for Mrs A to attend a consultation with him later that day.

Consultation 23 November 2009

25. Dr C saw Mrs A on 23 November 2009 but did not discuss with her the possibility of metastases as referred to in the radiologist's report. Dr C said that he focussed on the

[5] Tamoxifen is a drug that blocks the effects of oestrogen hormone in the body. It is used to treat breast cancer.

[6] Bony metastases, or metastatic bone disease, is cancer that has spread to the bone from a primary tumour.

torn tendon, which he attributed to the sporting incident Mrs A had told him about at the previous consultation.

26. Dr C administered a cortisone (steroid) injection into Mrs A's left shoulder and assisted her to complete an Accident Compensation Corporation (ACC) personal injury claim form. Mrs A stated that the pain during the steroid injection was excruciating.

27. Dr C advised Mrs A to return within four weeks for review if there was no clinical improvement or relief of her symptoms.

28. Mrs A said that Dr C told her that the imaging report stated that she had "torn a muscle in [her] left arm." Mrs A said she had the X-ray films with her and offered to show them to Dr C, but he declined to look at them. She advised that, at that time, the pain in her upper left arm immobilised it 90 percent of the time, causing her a considerable amount of stress and discomfort.

Consultation 18 December 2009

29. On 18 December 2009, Mrs A presented to Dr C with right-sided chest pain that had been ongoing for 10 days. Dr C cannot recall, nor did he record, Mrs A making any reference to pain in her left shoulder at that time. He thought there might have been reduced air entry into her lung, and arranged for her admission to a public hospital for urgent assessment and chest X-rays.

30. At the public hospital, Mrs A underwent a number of investigative tests including blood tests, an ECG and chest X-rays. No abnormalities were detected, and the pain was diagnosed as being musculoskeletal. Mrs A was kept overnight for observation and discharged home the following day. She was advised to return for review the following week if she was still experiencing ongoing pain.

Consultation 25 January 2010

31. On 25 January 2010, Mrs A again presented to Dr C with pain and discomfort in her left shoulder. She explained to him that the treatment to date had not helped. He referred her to an orthopaedic surgeon for review of her left shoulder problems.

Referral to orthopaedic surgeon

32. Dr C's 25 January 2010 referral letter to an orthopaedic surgeon stated that Mrs A had sustained her injury while playing sport, and that an ultrasound scan had confirmed a full thickness tear of the tendon in her left shoulder. The referral letter stated:

> "[Mrs A] has a painful L) shoulder from an injury she sustained [while playing sport] last year. An USS [ultrasound] confirmed a full thickness tear of her supraspinatus tendon. She has been treated conservatively with prescribed exercises and intra-articular corticosteroid injection. She has had a recent exacerbation and appears to be back where she started. I would value your assessment for best management."

33. Dr C made no reference to the radiologist's comments in the 23 November 2009 report regarding the possibility of bony metastases.

34. The referral to the orthopaedic surgeon documented Mrs A's medical history, with the following statement being the only reference to Mrs A's previous breast cancer: "13/06/2003: Ca L breast lobular infiltrating T2N0MX 03/03."

Consultation with orthopaedic surgeon

35. On 15 February 2010, Mrs A attended a consultation with orthopaedic surgeon Dr B.[7]

36. Dr B examined Mrs A's shoulders, noting that she had restricted movement in her left shoulder and that she was in a significant amount of pain. X-rays were taken and these confirmed the presence of a lytic lesion[8] in Mrs A's left shoulder. Dr B diagnosed a metastatic lesion in Mrs A's left shoulder, likely of breast origin given her medical history. He referred her for immediate admission to the public hospital, for investigation and histological diagnosis.

37. The public hospital undertook various tests on Mrs A and referred her to a medical and radiation oncology unit for review and treatment. Bony metastases were confirmed, and Mrs A was given chemotherapy and radiotherapy treatment.

38. Mrs A left Dr C's practice in 2010 and transferred her continuing care to another doctor.

39. Sadly, in 2014, Mrs A died.

Response from Dr C

40. Dr C's response to HDC acknowledged and expressed regret for his error of omission, which resulted in a delay in the diagnosis and treatment of Mrs A's cancer.

41. Dr C stated that the only explanation he can offer for omitting to action the abnormal imaging result at the 23 November 2009 consultation with Mrs A is that he either overlooked or completely forgot about the radiologist's comment in relation to a suspicious lesion, and focussed on the torn tendon.

The medical centre

42. Dr C, in his capacity as a director of the medical centre, advised that the medical centre had a "Management and Tracking of Medical Reports and Investigations Policy" in place in 2009 and 2010. The policy, in its entirety, stated the following:

"
- Results based current IT system.
- Not using lab request records.
- Results of lab tests and hospital letters received (hard copy and electronic).
- Received electronically and in hard copy by Doctor, who then annotates or files report after being read.
- Annotated lab results replicated in hard copy for nurse perusal and checking with electronic copy sent. When matched, unless instructed otherwise hard copy destroyed.

[7] Another orthopaedic surgeon.
[8] Destruction of an area of bone due to a disease process such as cancer.

- Hard copy is a back up for failure of practice information system.
- Computer backup on hard drive CD and to two memory sticks — one given to the Doctor each night to take away and one kept on the surgery premises, locked away with petty cash."

Responses to provisional opinion

43. Dr C submitted that his error in this case was an oversight in isolation and not something of a recurring nature. He said he "certainly never intended to overlook the result or fail to advise [Mrs A] of it".

44. Mrs A's partner made no comment in response to the provisional opinion.

Opinion: Breach — Dr C

45. Doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, results. This opinion highlights the importance of the effective and prompt communication of test results by providers to consumers[9] and the need to follow up abnormal results in a timely and effective manner. Dr C knew that Mrs A had previously been treated for cancer. Given the possible consequences of a recurrence, Dr C had a duty to be particularly vigilant.

46. I often refer to the mantra "read the notes, ask the questions, talk with the patient".[10] Doing the basics well matters. A repeat presentation for continuing left shoulder pain failed to elicit the most basic of enquiries. Dr C failed to read his own notes, even in relation to the last presentation by this patient for this concern, and apparently failed to reflect on the cancer history of his patient - which he nonetheless recorded in the referral letter. This consistent pattern of sub-optimal performance in relation to Mrs A is troubling.

47. Dr C's failures to inform Mrs A of the findings of the imaging report and to refer her appropriately for specialist care represent a severe departure from accepted practice.

Information about, and response to, imaging report

48. Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …" This includes information about the consumer's condition, and the results of tests.

49. On 23 November 2009, Dr C received Mrs A's imaging report, in which the radiologist, Dr D, commented that a full thickness tear of the tendon was evident. Dr D also made the following comment:

[9] See Opinion 10HDC01250 (22 February 2013), available at www.hdc.org.nz, for a discussion on this point.
[10] Anthony Hill, Health and Disability Commissioner, *NZ Doctor*, 9 March 2011.

> "Patient was in a lot of pain … I note that the patient has a history of being treated for breast malignancy. 'Moth-eaten' osteolytic changes are evident in proximal humeral shaft and extending through to the surgical neck of humerus, with bony erosion at its proximal medial margin. Appearances would be highly suggestive of metastasis. Bone scan and Oncologist specialist review is strongly recommended."

50. Dr C said that following his review of the abnormal imaging report, he intended to action the report in relation to the torn tendon and the possibility of bony metastases. He recorded in the PMS: "[T]orn tendon with changes of possible 2* spread." Dr C arranged for Mrs A to attend a consultation with him later that day.

51. My expert advisor, GP Dr David Maplesden, advised that Dr C demonstrated appropriate management on 23 November 2009 at the point when he acknowledged the significance of the imaging report, including the possibility of bony metastases, and appropriately arranged to see Mrs A.

52. Dr C saw Mrs A later that same day on 23 November 2009 but he did not discuss with her the possibility of metastasis referred to in the radiologist's report. Furthermore, Dr C did not arrange follow-up as recommended in the report. Dr C said that he either overlooked or forgot about the comment in the report.

53. Mrs A said that she had the X-ray films with her and offered to show them to Dr C, but he declined to look at them. This was a lost opportunity for Dr C to recognise his omission.

54. Dr C told Mrs A that the imaging report stated that she had torn a tendon in her left shoulder. He administered a cortisone injection into Mrs A's left shoulder and told her to return within four weeks for review if there was no clinical improvement or relief of her symptoms.

55. It is evident that when Dr C saw Mrs A that afternoon, he did not review the imaging report received earlier that day, or his own entry in PMS. Had he done so, he would have been reminded of the possibility of metastatic abnormality. This was a further missed opportunity. I note Dr Maplesden's view that Dr C's failure to discuss with Mrs A the possibility of metastatic disease at this consultation, despite his having acknowledged the report just hours earlier, constitutes a severe departure from accepted standards.

56. I agree with Dr Maplesden that "the proximity of the receipt and acknowledgement of the results to the consultation (a matter of hours), the nature of the abnormal result, and the fact that subsequent consultations failed to trigger a reminder of the abnormal result … must raise competency concerns". As Dr C did not review the records when he saw Mrs A on 23 November 2009, and did not arrange adequate timely follow-up, I find that Dr C failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

57. Dr C failed to fully inform Mrs A of the imaging results. I consider this failure to be of particular significance given the potential seriousness of the result in light of Mrs A's history of breast cancer. This is information that a reasonable consumer in Mrs

A's circumstances would expect to receive. Accordingly, I find that Dr C breached Right 6(1) of the Code.

Referral

58. On 25 January 2010, Mrs A attended a consultation with Dr C because she had pain and discomfort in her left shoulder. She explained to Dr C that the treatment to date had not resolved her symptoms. Dr C referred Mrs A to an orthopaedic surgeon.

59. Dr C's 25 January 2010 referral letter to the orthopaedic surgeon stated:

> "[Mrs A] who has a painful L) shoulder from an injury she sustained […] last year. An USS confirmed a full thickness tear of her supraspinatus tendon. She has been treated conservatively with prescribed exercises and intra-articular corticosteroid injection. She has had a recent exacerbation and appears to be back where she started. I would value your assessment for best management."

60. The referral letter made no mention of the possibility of bony metastases being present, as stated in the imaging report.

61. The referral documented Mrs A's medical history, with the following statement being the only reference to Mrs A's previous breast cancer: "13/06/2003: Ca L breast lobular infiltrating T2N0MX 03/03."

62. The applicable standards in relation to the referral of patients are set out by the Medical Council of New Zealand in the document *Good Medical Practice*.[11] According to that standard, good clinical care in relation to referring patients includes: "When you refer a patient, provide all relevant information about the patient's history and present condition."

63. The referral letter that Dr C sent was not of an appropriately professional standard because it did not provide the specialist with all the relevant information about Mrs A's clinical history. Accordingly, Dr C breached Right 4(2) of the Code.

Opinion: Adverse comment — The medical centre

64. The medical centre is a health care provider and an employing authority for the purposes of the Health and Disability Commissioner Act 1994. As such, it may be held directly liable for the inadequate care provided to Mrs A, and it may be held vicariously liable for any actions or omissions of its employees and/or agents who have been found to be in breach of the Code.

65. In my view, Dr C's failures in his communication and follow-up with Mrs A following receipt of the imaging report were matters of individual clinical judgement.

[11] Medical Council of New Zealand, *Good Medical Practice* (July 2008).

66. However, my Office asked the medical centre for its relevant policies. It advised that the medical centre had a "Management and Tracking of Medical Reports and Investigations Policy" in place in 2009 and 2010. The policy, in its entirety, stated the following:

> "
> - Results based current IT system.
> - Not using lab request records.
> - Results of lab tests and hospital letters received (hard copy and electronic).
> - Received electronically and in hard copy by Doctor, who then annotates or files report after being read.
> - Annotated lab results replicated in hard copy for nurse perusal and checking with electronic copy sent. When matched, unless instructed otherwise hard copy destroyed.
> - Hard copy is a back up for failure of practice information system.
> - Computer backup on hard drive CD and to two memory sticks — one given to the Doctor each night to take away and one kept on the surgery premises, locked away with petty cash."

67. Dr Maplesden advised me that the policy is inadequate, the wording of the policy is generally unclear, and "the process needs to be better recorded and more explicit and needs to incorporate particularly how 'important' referrals and results (eg suspected malignancy) are tracked." Dr Maplesden noted, in particular, that the policy does not:

- document how ordered tests/referrals are tracked to determine they are completed and/or completed in a timely manner;
- state explicitly whose responsibility it is to track or manage results, particularly when the test requester is absent; or
- address the issue of responsibility for notification of results, or of documentation around result notification.

68. It is notable that the policy makes no provision for an alert system. I have previously stated: "I consider that the establishment of an effective alert system is a reasonable precautionary action for a medical practice to take to ensure referrals are not lost or forgotten."[12] In my view, a medical practice should have a reminder or alert system to ensure that important information is not overlooked.

69. In my opinion, more care should have been taken by the medical centre to put in place adequate policies and procedures, including a reminder system that would not be subject to individual error. The medical centre should reflect on Dr Maplesden's comments about the adequacy of its policy, and the contribution of its poor systems to the unsatisfactory care provided to Mrs A.

[12] Opinion 10HDC00974 (15 June 2012) available at www.hdc.org.nz.

Recommendations

70. I recommend that Dr C take the following actions:

- Provide a written apology to the family of Mrs A. This should be sent to HDC within three weeks of the date of the final opinion, for forwarding to the family.
- Review the relevant aspects of his practice in light of this report, particularly in relation to the test result processes, and provide evidence to this Office of this review and the subsequent changes he has made to his practice within three weeks of the date of this report.
- Undertake an audit of his clinical records to ensure that all patient tests results he has received in the last two years have been appropriately followed up and communicated to patients. Dr C should provide evidence to this Office of this audit and its outcome within three months of the date of this report.

71. I recommend that the medical centre take the following action:

- Develop an appropriate policy or policies to ensure that test results are actioned and referrals are made in an adequate and timely manner, including an appropriate alert system. The medical centre should provide HDC with evidence of the development and implementation of the appropriate policy or policies within three months of the date of this report.

Follow-up actions

72.
- Dr C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name, with a recommendation that it consider a review of his competence particularly focussed on record-keeping, communication with patients, and test result follow-up.
- 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 the District Health Board, and they will both be advised of Dr C's name.
- 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.

Addendum

The Director of Proceedings decided to take no further action.

Appendix A — Clinical advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden on 20 August 2013:

"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 by [Dr C]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. [Mrs A] complains about the delay in diagnosis of metastatic bone cancer as the cause of her left shoulder pain following presentations to [Dr C] with shoulder pain in late 2009 and early 2010.

2. I have reviewed the GP notes. The notes are handwritten but it appears results are received electronically and filed in the PMS.

(i) [Mrs A] was 57 years old at the time of her presentation to [Dr C] with left shoulder pain on 16 November 2009. She had a past history [of] left sided breast cancer diagnosed in March 2003 and treated with partial mastectomy and Tamoxifen. [Mrs A] refers to being diagnosed with a shoulder injury on 25 September 2009. This was apparently the date of injury noted on ACC forms completed by [Dr C]. There is no documented consultation for 25 September 2009.

(ii) Notes for the consultation of 16 November 2009 refer to the complaint of left shoulder pain with some restriction of shoulder abduction and rotation consistent with a diagnosis of *rotator cuff syndrome*. Absence of numbness or tingling is documented. The pain was apparently attributed by [Mrs A] to an injury sustained [while playing sport] (noted in later orthopaedic notes) although this has not been recorded by [Dr C]. Treatment involved a prescription for Synflex and referral for X-ray and ultrasound.

Comment: The presentation and assessment was consistent with a rotator cuff injury, and initial management was appropriate to the diagnosis.

(iii) [Mrs A] had her imaging performed on 19 November 2009 and the films were reported that day and received by [Dr C] on 23 November 2009. The ultrasound confirmed the presence of a full thickness supraspinatus tendon tear and included the comments *Patient was in a lot of pain … of note is the presence of restricted range of movement*. Plain X-ray report (same document) included the comments *I note that the patient has a history of being treated for breast malignancy. 'Moth eaten' osteolytic changes are evident in proximal humeral shaft and extending through to the surgical neck of humerus, with bony erosion at its proximal medial margin. Appearances would be highly suggestive of metastasis. Bone scan and Oncologist specialist review is strongly recommended.*

(iv) [Dr C] has recorded (electronically) a comment on the result as *torn tendon with changes possible 2* spread* and provider [initials] has recorded *booked for consult today* — both comments 23 November 2009.

Comment: [Dr C] has acknowledged the significance of the imaging report, including the possibility of bony metastases, and has arranged to see [Mrs A] the same day. This was appropriate management.

(v) Consultation notes 23 November 2009 refer only to the procedure undertaken of intra-articular injection of steroid to the left shoulder joint *with some relief. Unable to abduct without pain prior to injection.* There is no reference to discussion of possible metastatic disease. [Mrs A] states she had her films with her and wanted to show them to [Dr C] but he declined.

Comment: In his response, [Dr C] acknowledges his oversight in not discussing the possibility of metastatic disease and in not arranging further recommended investigations. He is unable to explain how the oversight arose. It is concerning that a potentially very significant result was acknowledged by him and arrangements made to see the patient the same day, yet this same day he failed to action the results appropriately. **This was a severe departure from expected standards (the expected standards being that the significance of the result would be discussed with the patient and acted upon in an appropriate and timely manner). This was apparently a result of simple human error, but the proximity of the receipt and acknowledgement of the results to the consultation (a matter of hours), the nature of the abnormal result, and the fact that subsequent consultations failed to trigger a reminder of the abnormal result, I think must raise competency concerns sufficient to warrant referral to the Medical Council.** However, I acknowledge there may have been situational issues (distractors) relevant at the time of the events in question that have since been resolved. The Medical Council would be best placed to make this determination. [Dr C's] declining to review the X-ray films may have represented a missed opportunity to trigger a reminder regarding the abnormal report but does not in itself represent a departure from expected practice. GPs most commonly rely on the expertise of the reporting radiologist to determine radiological abnormalities.

(vi) On 18 December 2009 [Mrs A] attended [Dr C] with a complaint of right sided chest pain for 10 days. [Dr C] queried the presence of a pleural effusion and referred [Mrs A] to the public hospital ED where investigations including bloods, ECG and chest X-ray were performed and were apparently normal. There is no reference to ongoing left shoulder pain. The pain was diagnosed as musculoskeletal and [Mrs A] discharged with pain relief (paracetamol, ibuprofen and sevredol).

Comment: Management by [Dr C] was consistent with expected standards on this occasion.

(vii) On 25 January 2010 [Mrs A] returned for review complaining of persistent left shoulder pain and [Dr C] referred her for an orthopaedic opinion. The referral letter noted that [Mrs A] *had a painful L) shoulder from an injury she sustained [while playing sport] last year. An USS confirmed a full thickness tear of her supraspinatus tendon. She has been treated conservatively with prescribed exercises and intra-articular corticosteroid injection. She has had a recent exacerbation and appears to be back where she started.* A summary of [Mrs A's] medical history, including breast cancer, is included in the referral but there is no reference to the imaging report suggestive of bony metastatic disease. [Mrs A] was seen by orthopaedic surgeon [Dr B] on 15 February 2010 who noted *in September 2009* [Mrs A] *developed pain in the anterior aspect of her left shoulder, radiating down to her arm on occasion. There was no specific history of*

trauma. She has had a gradual deterioration over the last 4 months … she has significant night pain and rest pain … she has had a subacromial steroid injection which gave her no significant symptomatic relief. Examination showed tenderness over the proximal humerus and global restriction in shoulder movement, but difficult examination due to pain. *Xrays today confirmed a lytic lesion in her proximal humerus … I have explained it is likely to represent a metastasis, most likely of breast origin given her history.* [Dr B] arranged immediate hospital admission for [Mrs A]. Bony metastases were confirmed and treatment given with chemo-radiotherapy.

Comment: [Dr C's] oversight resulted in [Mrs A's] diagnosis of bony metastasis being delayed for three months. While the effect of this on her overall prognosis and clinical course may not be notable, [Mrs A] was denied timely treatment which may have reduced her suffering, and improved her quality of life, over this period."

Dr Maplesden provided the following additional advice in relation to the medical centre's "Management and Tracking of Medical Reports and Investigations Policy":

"1. You have asked for comment on the adequacy of [the medical centre's] policy on handling of results. [The medical centre] has advised that in terms of their policy for the handling of results they had a 'Management and Tracking of Medical Reports and Investigations Policy' in place in 2009 and 2010. The policy, in its entirety, is as follows:

'• Results based current IT system.
- Not using lab request records.
- Results of lab tests and hospital letters received (hard copy and electronic).
- Received electronically and in hard copy by Doctor, who then annotates or files report after being read.
- Annotated lab results replicated in hard copy for nurse perusal and checking with electronic copy sent. When matched, unless instructed otherwise hard copy destroyed.
- Hard copy is a back up for failure of practice information system.
- Computer backup on hard drive CD and to two memory sticks – one given to the Doctor each night to take away and one kept on the surgery premises, locked away with petty cash.'

2. Relevant standards:
(i) The RNZCGP 'Aiming for Excellence' Cornerstone accreditation standards[1] (2011 version quoted but this has not changed substantially from previous years):

Practices must operate a reliable and defined process for recording and managing clinical investigations. There should be a clear indication of what action was initiated on all reports to enable correct tracking and management.

[1] See: https://www.rnzcgp.org.nz/assets/documents/CORNERSTONE/Aiming-for-Excellence-2011.pdf (pg 46).

The principle is that patient reports are not lost in the system and are processed to ensure the right people get the right information within the time frames identified by the practice. For every report or test there must be a person in the practice responsible for management and tracking. Good practice requires that practices should keep a record of telephone conversations with patients about test results, noting the date and who advised the patient … There is a documented policy that describes how laboratory results, imaging reports, investigations and clinical correspondence are tracked and managed … All incoming test results or other investigations are sighted and actioned by the team member who requested them or by a designated deputy … Patients are provided with information about the practice procedure for notification of test results …

(ii) Broader standards are considered in the MCNZ publication Coles Medical Practice in New Zealand[2] and reference is made to another RNZCGP publication as follows:

After considering the Commissioner's reports and the case heard at the District Court the RNZCGP developed a resource called Advice on minimising error in patient test result management, *which included these principles:*

a. General practice is encouraged to develop a system to audit and manage patient test results.

b. This system should not rely on the patient taking the first step in the notification process. However, patients should be able to enquire about their results as a backup to the practice's notification system.

c. Clear information on the practice's system for notification of test and procedure results should be made available and explained to patients.

d. In specific cases, where the general practitioner suspects significant pathology, the practitioner needs to ensure the practice system tracks requests and return of the results to the practice and manages the result in an appropriate and timely manner.

e. ***A clear policy is required covering the test initiator, notifications, locums and follow up.***

The paper acknowledged that different organisational structures and procedures among general practices and patient populations made it difficult to provide easy solutions to managing patient test results, and identified a number of issues and challenges.

3. I have examined [the medical centre] from the perspective of a locum GP seeking guidance from the policy as to how results are handled and tracked at [the medical centre]. I think the policy is deficient in several aspects:

[2] St George IM 2013. The management of clinical investigations. Chapter 14 in St George IM (ed.). Cole's medical practice in New Zealand, 12th edition. Medical Council of New Zealand, Wellington.

(i) it does not document how ordered tests/referrals are tracked to determine they are completed, and/or completed in a timely manner

(ii) it does not state explicitly whose responsibility it is to track or manage results, particularly when the test requestor is absent

(iii) it does not address the issue of responsibility for notification of results, or of documentation around result notification (although this may be addressed in a separate policy)

(iv) The wording of the policy is generally unclear I think as a result of its brevity.

4. In conclusion, I think the standard of the written policy is inadequate and a mild departure from expected standards. This does not imply the actual processes undertaken at [the medical centre] are inadequate, but the process needs to be better recorded and more explicit and needs to incorporate particularly how 'important' referrals and results (eg suspected malignancy) are tracked."