General Practitioner, Dr C
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 19HDC01086)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report considers the care provided to a woman after she presented to her general practitioner (GP) with symptoms of post-menopausal bleeding (PMB). The report highlights the importance of thorough investigation of PMB symptoms, including timely referral for further investigation if indicated.

2. The woman first saw the GP in July 2018 with PMB symptoms. She saw him again in September 2018 and January 2019. The GP documented that largely her PMB had settled. However, in May 2019, the woman returned to the medical centre and saw a different GP. This GP undertook a bimanual and speculum examination and discovered a tumour on the woman's cervix. A subsequent cervical biopsy confirmed that she had advanced cervical cancer.

Findings

3. The Commissioner found the GP in breach of Right 4(1) of the Code for failing to document anything about a speculum examination at the July 2018 consultation, and for failing to: (a) visualise the woman's cervix; (b) complete a bimanual examination or a cervical smear; and (c) refer her for a transvaginal ultrasound at the September 2018 consultation.

4. The Commissioner considered that the errors that occurred in this case did not indicate broader systems or organisational issues, and therefore that the medical centre did not breach the Code.

Recommendations

5. The Commissioner recommended that the GP provide a written apology, and that the Medical Council of New Zealand consider whether a review of the GP's competence is warranted.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her mother by Dr C. The following issues were identified for investigation:

- *Whether Dr C provided Mrs A with an appropriate standard of care between July 2018 and March 2019 (inclusive).*
- *Whether the medical centre provided Mrs A with an appropriate standard of care between July 2018 and March 2019 (inclusive).*

7. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant/consumer's daughter
Dr C	Provider/general practitioner
Medical centre	Provider/general practice

Also mentioned in this report:

Dr D	General practitioner

8. Further information was received from the district health board.

9. Expert advice was obtained from HDC's in-house clinical advisor, GP Dr David Maplesden (Appendix A).

Information gathered during investigation

Background

Mrs A

10. At the time of her first GP appointment about her post-menopausal bleeding (PMB), Mrs A was in her early eighties.

Dr C and the medical centre

11. The medical centre advised HDC that prior to the events, GP Dr C[1] ran his own medical practice as part of a cost-sharing partnership in the medical centre. The partnership was dissolved and a new company was formed, which bought out Dr C's practice (among others). Dr C was then engaged as a contractor to provide GP services to the medical centre. HDC was provided with a copy of Dr C's contract with the medical centre. It explicitly states that Dr C is engaged as an independent contractor and not as an employee, agent, or partner of the medical centre. The contract further states that Dr C had no authority to bind the medical centre to any enforceable commitment or contract.

July 2018 — first consultation

12. On 26 July 2018, Mrs A attended an appointment at the medical centre because she had been experiencing PMB. She was seen by her regular GP, Dr C. Dr C recorded in the clinical notes:

> "some browny disch[arge] ? blood stained
>
> no pain
>
> [On examination] fleshy urethral caruncle[2] ? polypoid and vag wall

[1] Dr C has been registered in the General scope of practice for many years. He is not vocationally registered.
[2] A small fleshy growth.

some vaginitis[3] \
plan ovestin[4] and [check] in [one month]."

13. Dr C told HDC that Mrs A did not report any other symptoms beyond the brown-coloured vaginal discharge. He stated:

> "A speculum examination was attempted at this time, however due to discomfort it was not persisted with and I could not visualise her cervix. After discussion it was agreed that [Mrs A] would use an oestrogen cream daily applying this to the caruncle and she was instructed to return in one month for a repeat and check on progress."

14. Dr C told HDC that he did not document his attempted speculum examination because it was not completed fully.

15. Mrs A told HDC that her discharge was blood, and she never described it as brown. She said that prior to her appointment with Dr C, she had been bleeding on and off (bleeding for a few days, then no bleeding for approximately three weeks, then again bleeding for a few days).

16. Mrs A cannot remember the nature of the physical examination undertaken by Dr C at this appointment, including whether or not he used a speculum. However, she does not recall experiencing any discomfort during the examination, and does not recall telling Dr C that she was experiencing discomfort. In response to the provisional opinion, Mrs A commented that the only time she recalled experiencing discomfort was when a cervical biopsy was performed at a later consultation with a different provider.

17. Mrs A also cannot recall being told to return in a month's time, and stated that had Dr C advised her of this, she would have done so. Instead, Mrs A's next appointment took place two months later.

September 2018 — second consultation

18. On 26 September 2018, Mrs A returned to the medical centre and was seen again by Dr C. Dr C recorded in the clinical notes:

> "check largely disch[arge] stopped vag mucosa healthy with no obvious caruncle
>
> speculum exam[ination] all looks normal but will return if further bleed."

19. Dr C told HDC that Mrs A reported that the discharge had stopped. He said that he instructed her to continue using the oestrogen cream on a weekly basis, and to return if there was any further bleeding. He stated:

> "I did not attempt to visualise [Mrs A's] cervix on 26 September 2018 because when I conducted the speculum examination, the speculum wouldn't pass to the end of the

[3] Inflammation of the vagina (eg, from bacterial or fungal infection, allergic reaction, or hormone deficiency) that may be marked by irritation and vaginal discharge.
[4] Oestrogen vaginal cream.

> vagina and she again experienced discomfort. I felt it reasonable in the absence of bleeding and the caruncle having disappeared which I felt was the cause of her problems, to delay referral for a TVUS.[5]
>
> … [Mrs A] had reported she had had no previous abnormal smears. If this had been the case I would have been more suspicious that cervical pathology could exist."

20. Mrs A told HDC that at this consultation she would not have told Dr C that the bleeding had stopped, because the bleeding had been continuing in the same on/off pattern. Mrs A stated that Dr C told her that she had "nothing to worry about", it was just polyps, and that she should continue to use the oestrogen cream.

30 January 2019 — third consultation

21. Mrs A returned to the medical centre on 30 January 2019 for a repeat prescription and a medical assessment of her fitness to drive. Dr C wrote in the clinical notes that Mrs A also reported "no further bleeding and will use cream maybe monthly will report any blood".

22. Mrs A told HDC that again she believes that at this consultation she would not have told Dr C that the bleeding had stopped, because the bleeding had been continuing in the same on/off pattern. However, Dr C told HDC that when he questioned Mrs A at this consultation, she reported no further problems with discharge or bleeding. In response to the provisional opinion, Mrs A's daughter noted that her mother was adamant that the bleeding was continuing on and off at this time.

Subsequent events

23. Dr C ceased providing GP services at the medical centre in early 2019.

24. On 1 May 2019, Mrs A returned to the medical centre and was seen by GP Dr D. Dr D told HDC that Mrs A presented for repeat prescriptions of her regular medications, one of which was Ovestin. Dr D stated:

> "[Mrs A] explained that she had a recent recurrence of a pinkish vaginal discharge, for which her previous GP has prescribed Ovestin cream in September 2018. She had no other symptoms related to this discharge. When I asked if she had been examined vaginally, she said that she did not recall an internal examination."

25. Dr D documented in the clinical notes:

> "Getting some pinkish PV discharge, no itch, no pelvic or perineal pain. Periods long since stopped, reported this to previous GP Sept 2018 and [was prescribed] ovestin cream. Discharge has only recently reappeared. No UTI symptoms. Smears were all normal.

[5] Transvaginal ultrasound.

> … [On examination] pinkish discharge on pad. [Per vagina] — vulva NAD,[6] vagina atrophic. On bimanual exam, palpable mass on cx.[7] With speculum, cauliflower-like mass on cx, pale, not obviously bleeding."

26. Dr D told HDC that she advised Mrs A that a mass was present, and that she was very concerned that it could be cancer. Later that day, Dr D sent an urgent referral to the DHB's Gynaecology Clinic, noting that there was a high suspicion of cancer.

27. On 22 May 2019, Mrs A attended an appointment at the Gynaecology Clinic. On examination, the doctor noted that Mrs A "had a large exophytic tumour of the cervix extending out to the vaginal walls. The cervix had almost completely eroded away." The doctor advised Mrs A of her findings and told her that most likely radiotherapy would be the treatment of choice.

28. On 29 May 2019, the laboratory reported that the cervical biopsy showed moderately differentiated squamous cell carcinoma. A CT scan carried out on 4 June 2019 reported the cancer as a probable stage II.

29. Subsequently, Mrs A was referred to another DHB for radiation therapy. On 19 June 2019, Mrs A was examined by a radiation oncologist, who noted:

> "[Mrs A] has a large cervical tumour eroding the whole cervix and most prominently eroding the anterior vaginal wall by more than 50%. … [I]t was almost 6cm in length, and there was only 4cm left of her vagina which was free of the disease. This was bleeding on touch."

Further information

Mrs A

30. Mrs A told HDC that Dr C had been her doctor for a long time prior to these events, so what happened was pretty disappointing.

Dr C

31. Dr C told HDC:

> "Cervical cancer was considered as part of the differential diagnosis and it was noted [Mrs A] had never had any abnormal smears previously. Because of the difficulty and discomfort in visualizing her cervix at her initial presentation and the presence of an inflamed urethral caruncle I felt it reasonable to treat the caruncle and see if the discharge stopped. Checks in September 2018 and January 2019 revealed no further discharge or bleeding. Subsequent speculum examination was normal.
>
> … In hindsight, I accept that the cancer may have been present at her initial presentation but not discovered until her vaginal discharge recurred in May 2019. I regret that the cancer was not diagnosed earlier."

[6] No abnormalities detected.
[7] Cervix.

32. Dr C further stated that he has had considerable time to reflect on his treatment and investigation of Mrs A, and he is sincerely sorry that the improvement in symptoms did not mean that the problem had resolved.

33. Dr C advised that he retired from the medical centre in early 2019, but currently is working in the region. He also undertakes occasional duties at an after-hours medical centre, and short-term locum appointments. He does not intend to renew his practising certificate when it expires in 2020.

Medical centre

34. The medical centre told HDC:

> "All GPs working in [the medical centre] undergo 360degree peer assessments and are all encouraged and supported to take part in continuing professional development, however this is not an expectation or requirement under Cornerstone accreditation.
>
> Because [Dr C] was not vocationally registered, he was required to meet BPAC standards.[8] [Dr C] attended peer groups, and also attended regular monthly clinical team meetings at [the medical centre], all of which had some case review and peer review content.
>
> There was little opportunity to provide specific training to mitigate any potential risks identified in [Dr C's] ongoing practice. He returned to [the medical centre] in February 2019 then left again [a short time] later.
>
> … [T]his experience with [Dr C] has been extremely distressing and disruptive for the medical centre. As a result, we recruited vocationally registered GPs to look after [Dr C's] patient group.
>
> [The medical centre] now only contracts or employs GPs who are either vocationally registered or working towards vocational registration with RNZCGP."[9]

35. At the time of events, the medical centre was (and continues to be) a Cornerstone-accredited practice.[10] The medical centre advised HDC that it has in place all relevant policies as required by Cornerstone and the RNZCGP. There is no requirement for practices to have in place policies on clinical examination and documentation.

Responses to provisional opinion

36. Mrs A, Dr C, and the medical centre were all given the opportunity to respond to relevant sections of my provisional opinion.

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[8] Doctors registered in the General scope of practice and who are not in a vocational training programme are required to take part in the Inpractice recertification programme administered by bpacNZ (Best Practice Advocacy Centre New Zealand).

[9] The Royal New Zealand College of General Practitioners.

[10] CORNERSTONE is an assessment programme that assesses medical practices using the RNZCGP's *Aiming for Excellence* standard. RNZCGP states that the *Aiming for Excellence* standard is the quality standard for general practice in New Zealand.

37. Neither Dr C nor the medical centre wished to provide any further comment.

38. Where relevant, Mrs A's comments have been incorporated into the report. In addition, Mrs A and her family commented:

> "[Mrs A] feels disappointed that this is her word against [Dr C's] but we believe this should have been discovered at her first or even second GP appointment or a referral should have at least been made to the Gynaecologist."

Opinion: Dr C — breach

July 2018 consultation

39. Mrs A first presented to Dr C on 26 July 2018 with post-menopausal bleeding. Dr C documented that Mrs A had "some browny disch[arge] ? blood stained", while Mrs A said that she never described her discharge as brown coloured, and that it was definitely blood.

40. Dr C said that at this consultation he attempted a speculum examination, but did not complete it as Mrs A was too uncomfortable. Dr C documented his examination findings that Mrs A had a degree of vaginitis and a fleshy urethral caruncle. He prescribed Mrs A an oestrogen cream to be used daily, and instructed her to return in a month's time. Conversely, Mrs A told HDC that she does not recall being told to return in a month's time, and she believes that had she been instructed to, she would have done so.

41. My in-house expert advisor, Dr David Maplesden, advised that recommended practice for managing post-menopausal bleeding is to proceed with speculum and bimanual examinations with a cervical smear. Dr C did not complete the speculum examination or take a cervical smear. However, Dr Maplesden considers that if Dr C attempted a speculum examination, his management strategy for Mrs A at the 26 July 2018 consultation was reasonable for the following reasons:

> "[Mrs A's] symptoms were mild and there was an obvious local cause for the symptoms (although the presence of local signs of oestrogen deficiency does not obviate the need for further assessment and investigation as per the cited guidance); [Mrs A] could not currently tolerate a speculum and bimanual examination; a one month course of topical oestrogen is likely to have made subsequent speculum and bimanual examination more tolerable; it was reasonable to exclude obvious cervical pathology prior to referral for TVUS.[11] Provided the importance of the four-week follow-up was emphasised to [Mrs A], I feel her management on this occasion was reasonable."

42. I accept Dr Maplesden's advice. However, I am concerned that there is a question as to whether Dr C did attempt a speculum examination. Dr C did not document an attempted

[11] Transvaginal ultrasound.

speculum examination, or reasons for being unable to complete it. Mrs A told HDC that she does not recall experiencing any discomfort during the examination, or telling Dr C that she was experiencing discomfort. I also note that Mrs A later told Dr D on 1 May 2019 that she could not recall Dr C carrying out an internal examination.

43. Due to the conflicting accounts, and the lack of documentation about any attempted speculum examination, I am unable to determine whether Dr C did attempt a speculum examination. However, in any event, if Dr C was unable to complete a speculum examination, he should have documented this thoroughly, with the reasons for being unable to complete the examination, and I am critical that he failed to do so.

September 2018 consultation

44. Mrs A returned to see Dr C two months later, on 26 September 2018. Dr C documented that largely Mrs A's vaginal discharge had stopped. Conversely, Mrs A believes that at this consultation she would not have told Dr C that the bleeding had stopped, because the bleeding had been continuing in the same on/off pattern.

45. Dr C documented that there was no longer an obvious caruncle, and that he undertook a speculum examination and everything looked "normal". Dr C did not, however, document having completed a bimanual examination, and did not document whether he viewed Mrs A's cervix. He told HDC that he did not visualise Mrs A's cervix during this examination because "the speculum wouldn't pass to the end of the vagina and [Mrs A] again experienced discomfort". Dr C stated that he instructed Mrs A to continue using the oestrogen cream every week and to return if she experienced further bleeding.

46. I accept that Dr C did carry out a speculum examination at this consultation but did not visualise Mrs A's cervix. However, there is no evidence that Dr C carried out a bimanual examination.

47. Dr Maplesden advised that accepted practice at this consultation would have been to complete bimanual and speculum examinations, visualising the cervix, carrying out a cervical smear, and referring for TVUS. Dr Maplesden further advised:

> "[Dr C's] failure to perform these steps represents a significant departure from accepted practice. Taking into account the mitigating factors of concurrent pathology which could explain the symptoms (urethral caruncle), apparent response to oestrogen cream, attempt to undertake speculum examination, and safety-netting advice apparently provided to report recurrence of symptoms, I believe [Dr C's] management of [Mrs A's] condition departed from accepted practice to a moderate degree."

48. I also note the radiation oncologist's examination findings on 19 June 2019 that Mrs A had a "large cervical tumour eroding the whole cervix and most prominently eroding the anterior vaginal wall by more than 50%". Dr Maplesden commented:

> "This was very extensive disease and … even though it was by now nine months since the speculum examination documented by [Dr C] it appears quite likely that adequate

> visualization of the cervix and upper vagina in September 2018 might have shown some macroscopic abnormality,[12] and this could raise some concern regarding the adequacy of [Dr C's] examination of [Mrs A] at this time."

49. It is not possible to determine, and it is not my role to determine, that any cervical abnormalities would have been detected had Dr C visualised Mrs A's cervix appropriately and completed a bimanual examination or a cervical smear, and/or referred Mrs A for TVUS. Nonetheless, I accept Dr Maplesden's advice and I am critical that Dr C failed to complete any of these steps. His failure to do so could well have delayed the diagnosis and, consequently, the treatment of Mrs A's cervical cancer.

Conclusion

50. There were a number of deficiencies in the care provided by Dr C to Mrs A. Specifically, Dr C failed to:

- Document anything about a speculum examination at the 26 July 2018 consultation.
- Visualise Mrs A's cervix, complete a bimanual examination or a cervical smear, and refer Mrs A for TVUS at the 26 September 2018 consultation.

51. I therefore find that Dr C failed to provide Mrs A services with reasonable care and skill and, accordingly, that Dr C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: Medical centre — no breach

52. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. The medical centre is a Cornerstone-accredited practice. I note that this means that the medical centre has demonstrated compliance with certain quality indicators and criteria. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

53. I also note the comments of my in-house expert advisor, Dr David Maplesden:

> "The practice has taken what appears to be a prompt, conscientious and appropriate response to these concerns with patient safety a paramount consideration. It is difficult to see what other steps the practice might have taken prior to potential competency issues being raised, to detect the concerns later identified."

54. The medical centre responded swiftly and conscientiously to the concerns about Dr C's practice.

[12] Cosper P et al. Cervical Tumor Volume Doubling Time: A Pilot Study. Rad Oncol. 2015;93(3):e258–e259.

Recommendations

55. I recommend that Dr C provide a written apology to Mrs A for the failures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

56. I recommend that the Medical Council of New Zealand consider whether a review of Dr C's competence is warranted based on this report.

Follow-up actions

57. 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.

58. 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 NZ College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from GP Dr David Maplesden:

"1.Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the available information: complaint from [Ms B]; response from [Dr C]; statement from [Dr D]; [medical centre] clinical notes; [DHB] clinical notes.

2. [Ms B] complains about the management of her mother, [Mrs A], by [Dr C] at [the medical centre]. She states [Mrs A] attended [Dr C] in the latter half of 2018 having had post-menopausal vaginal bleeding. [Dr C] told her *that her uterine wall had thinned.* [Mrs A] had a further episode of bleeding in early 2019 and was prescribed a cream by [Dr C]. She was not referred for further investigations at either appointment. On 23 May 2019 [Mrs A] attended a different GP at [the medical centre] with ongoing bleeding symptoms and she was referred to secondary care [at the DHB] for further investigation which revealed inoperable cervical cancer. [Ms B] is concerned at the delay in her mother's diagnosis.

3. Response from [Dr C] includes the following points:

(i) [Mrs A] (aged [in her early eighties]) attended [the medical centre] on 26 July 2018 with a history of *brown-coloured vaginal discharge which may have been blood stained. She reported no pain or other symptoms.* On examination [Mrs A] had a fleshy inflamed urethral caruncle and a degree of vaginitis. Speculum examination was attempted but was too uncomfortable to complete so the cervix was not viewed. [Mrs A] was prescribed an oestrogen cream and *instructed to return in one month for a repeat exam and to check on progress.*

(ii) [Mrs A] returned for review on 26 September 2018. Her discharge had stopped. *Examination at this stage showed health[y] vaginal mucosa with no obvious caruncle.* Speculum examination was recorded as normal and [Mrs A] was instructed to continue using the oestrogen cream on a weekly basis and to return if there was any further bleeding.

(iii) [Mrs A] was seen for a drivers' license medical examination on 30 January 2019. *She reported no bleeding and was instructed to use the cream monthly, but to return and report any further bleeding.*

(iv) [Dr C] retired in [early] 2019 and notes [Mrs A] returned to [the medical centre] in May 2019 with a history of pinkish vaginal discharge which was later revealed to be due to cervical cancer. [Dr C] states [Mrs A] had a normal cervical smear history and reiterates the safety netting advice provided on each occasion he reviewed her.

4. Statement from [Dr D] of [the medical centre] includes the following points:

(i) [Dr D] first met [Mrs A] on 1 May 2019 when she presented for a repeat of her usual medications which included Ovestin cream. [Mrs A] noted she had a recurrence of a pinkish vaginal discharge for which [Dr C] had prescribed the cream in September 2018. On questioning, [Mrs A] did not recall ever having had an internal examination in relation to the symptom so [Dr D] undertook the examination.

(ii) [Dr D] notes that on speculum examination *there was a large palpable mass … extending from her cervix.* [Dr D] referred [Mrs A] to [the DHB's] gynaecology service with high suspicion of cancer. [Dr D] notes there were no cervical smear results on file ([Mrs A] had transferred to [the medical centre] in 2009) but this would not be unusual given [Mrs A's] age [in women with an unremarkable smear history, routine cervical smears stop at age 69 years].

5. Clinical notes review

(i) [Medical centre] notes dated 26 July 2018 ([Dr C]) include: *some brown disch ?bloodstained, no pain. O/E fleshy urethral caruncle ?polyposis and vag wall some vaginitis. Plan ovestin and check in 1/12.* Routine repeat medications were prescribed together with Ovestin cream.

(ii) [Medical centre] notes dated 26 September 2018 ([Dr C]) include: *check, largely disch stopped, vag mucosa healthy with no obvious caruncle, speculum exam all looks normal but will return if further bleed.* Further Ovestin cream was prescribed.

(iii) [Medical centre] notes dated 30 January 2019 ([Dr C]) include: *no further bleeding and will use cream maybe monthly, will report any blood …*

(iv) [Medical centre] notes dated 1 May 2019 ([Dr D]) include: *Getting some pinkish PV discharge, no itch, no pelvic or perineal pain. Periods long since stopped, reported this to previous GP Sept 2018 and Rxd ovestin cream. Discharge has only recently reappeared. No UTI symptoms. Smears were all normal … O/E pinkish discharge on pad. PV — vulva NAD, vagina atrophic. On bimanual exam, palpable mass on cx. With speculum, cauliflower like mass on cx, pale, not obviously bleeding. Plan — urgent ref to gynae clinic.*

(v) [The DHB's] gynaecology report dated 22 May 2019 includes: [Mrs A] *is [a woman in her early eighties] who has been having some post-menopausal bleeding on and off for probably nine months or so. She was rather vague. It is only spotting when wiping and feels as though it is slightly better at the moment and she was given some estrogen cream which seems to have improved it somewhat ... On examination she had a large exophytic tumour of the cervix extending out to the vaginal walls. The cervix had almost completely eroded away and there was an area of corkscrew vessels …* Biopsies revealed a moderately differentiated squamous cell carcinoma of the cervix with subsequent staging investigations revealing local extension of the tumour to involve the vaginal wall but no evidence of metastatic disease. [Mrs A] was to undergo radiotherapy.

6. Accepted local management of a patient presenting with post-menopausal bleeding is outlined in a Map of Medicine pathway made available to GPs by [the] DHB[1]. The management algorithm is presented as appendix 1. Further detail on some of the 'nodes' relevant to this complaint include:

(i) Node 11. *Examination and cervical smear*

- *check for signs of systemic disease e.g. bruising for coagulopathy*
- *an abnormal examination and bimanual palpation of the pelvic area*
- *a speculum examination of the vagina and cervix*
- *cervical smear for cytology*
- *an assessment of uterus size*
- *check for any tenderness or visible discharge*

(ii) Node 14. *Transvaginal Ultrasound (TVUS)*

Refer women for an urgent ultrasound scan to assess endometrial thickness. A transvaginal scan can:

- *reliably assess the thickness and morphology of the endometrium*
- *can identify women with post-menopausal bleeding who have thin endometrium and are therefore unlikely to have significant endometrial disease or require further investigations*

(iii) Nodes 20, 21 and 25 recommend that if initial examination including cervical smear is not suspicious for malignancy, and TVUS has shown endometrial thickness ≤ 4mm, it is reasonable to treat for atrophic vaginitis with oestrogen cream, review after two months and if symptoms have resolved maintain topical oestrogen treatment.

7. It appears that on 26 July 2018 [Dr C] established [Mrs A] had a symptom suggestive of intermittent post-menopausal bleeding (PMB). It is unclear what access he had to [Mrs A's] cervical smear history but he had been [Mrs A's] GP for many years and could not recall any history of abnormal smears. [Mrs A] had no obvious factors increasing her background risk of endometrial cancer. [Dr C] performed a satisfactory and adequately documented external genital examination, establishing possible local causes for the bleeding (urethral caruncle and atrophic vaginitis changes). Recommended practice is to proceed with speculum and bimanual examinations with cervical smear. [Dr C] attempted to do this but stopped because of the discomfort it was causing [Mrs A]. The documented plan was to treat the atrophic changes noted with oestrogen cream and review in one month with more complete examination. I think this was a reasonable management strategy for the following reasons: [Mrs A's] symptoms were mild and there was an obvious local cause for the symptoms (although the presence of local signs of oestrogen deficiency does not obviate the need for further assessment and investigation as per the cited guidance); [Mrs A] could not currently tolerate a speculum and bimanual examination; a one

[1] Post-menopausal bleeding (PMB). Accessed 30 July 2019

month course of topical oestrogen is likely to have made subsequent speculum and bimanual examination more tolerable; it was reasonable to exclude obvious cervical pathology prior to referral for TVUS. Provided the importance of the four-week follow-up was emphasised to [Mrs A], I feel her management on this occasion was reasonable.

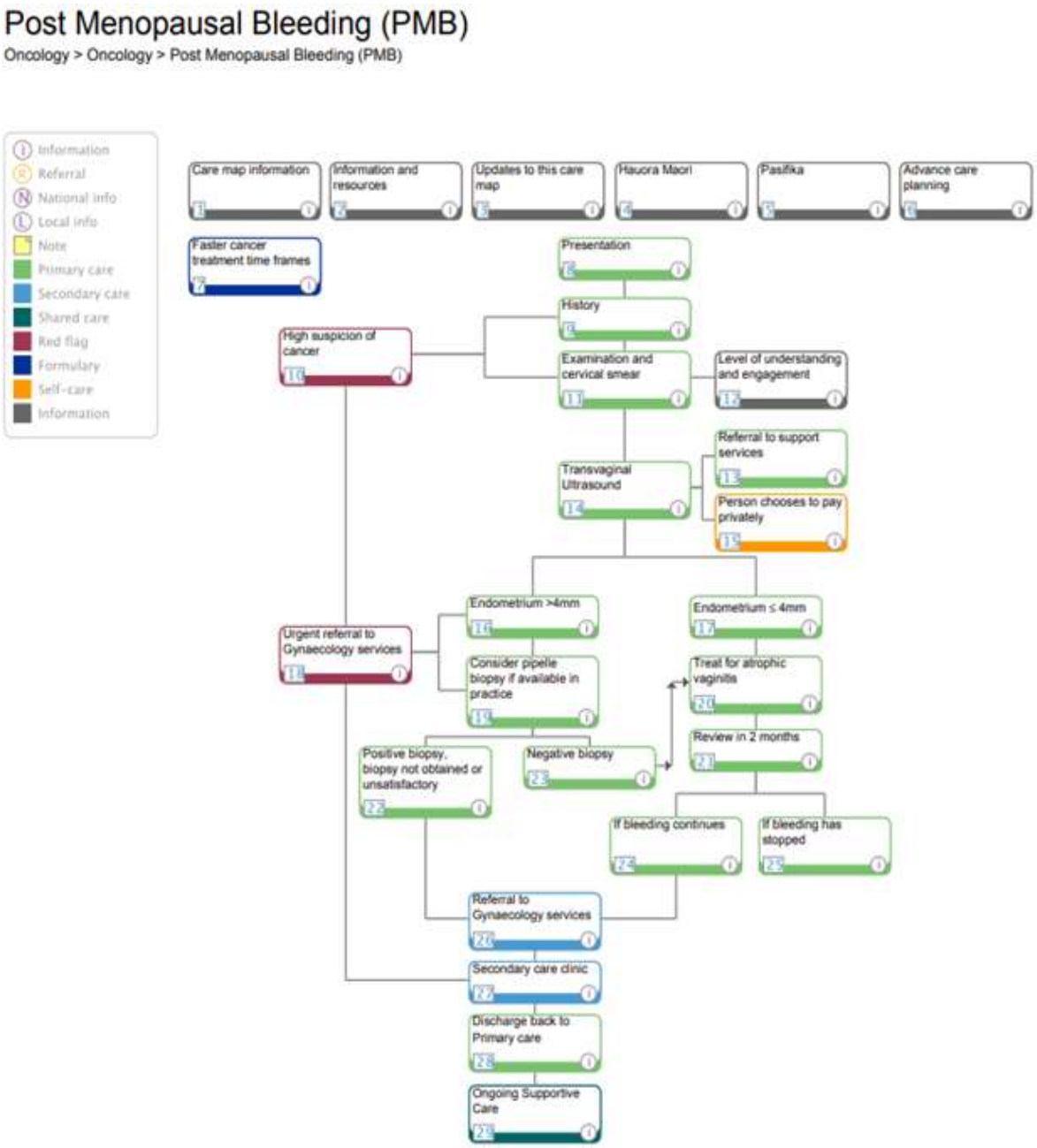
8. [Mrs A] attended for follow-up as instructed although it was two months since the initial assessment. Her symptoms had 'largely resolved' suggesting the oestrogen cream was effective. [Dr C] records completing a speculum examination which was apparently normal. There is no specific reference to the cervix being viewed (best practice is to record relevant negative as well as positive findings) and cervical smear was not performed. There is no reference to bimanual examination being performed. With the benefit of hindsight, and noting the extent of [Mrs A's] cancer (moderately differentiated) eight months after this September 2018 assessment, it seems likely (although not unequivocal) there might have been some visible or palpable cervical abnormality present at this time, or at least a high chance of microscopic abnormality being detected if a cervical smear was performed. Recommended practice, following speculum/bimanual examination and cervical smear, is to refer for TVUS to assess endometrial thickness. While atrophic changes secondary to hypo-oestrogenism is the most common cause of PMB, around 10% of cases are due to endometrial cancer[2] and the two pathologies often co-exist. I believe [Dr C's] failure to refer [Mrs A] for TVUS was a moderate departure from accepted practice, mitigating factors being presence of atrophic vaginal and urethral changes and apparent resolution of symptoms with topical oestrogen therapy. However I acknowledge, with the benefit of hindsight, that TVUS may not have identified the cause of [Mrs A's] bleeding. I would be moderately critical if satisfactory views of the cervix were not obtained as part of the speculum assessment. Cervical smear should have been considered, particularly if there was any macroscopic abnormality of the cervix, although had there been a macroscopic abnormality of the cervix, specialist referral was required irrespective of the smear result.

9. At review on 30 January 2019, [Mrs A's] PMB symptoms appeared to have resolved with use of the oestrogen cream, supporting the diagnosis of atrophic changes as the cause of the symptoms. Adequate safety netting advice was provided on this and previous occasions. Had [Mrs A] been investigated appropriately prior to this consultation with those investigations being normal (no macroscopic cervical abnormality, smear normal, endometrial thickness on TVUS ≤ 4mm), her management by [Dr C] on 30 January 2019 would have been reasonable.

10. Management of [Mrs A] by [Dr D] on 22 May 2019 was clinically appropriate."

[2] Brand A. The woman with postmenopausal bleeding. Aust Fam Phys. 2007;36(3):116–120 https://www.racgp.org.au/afpbackissues/2007/200703/200703brand.pdf Accessed 30 July 2019

Appendix 1[3]



[3] Post-menopausal bleeding (PMB). Accessed 30 July 2019

The following further advice was obtained from Dr Maplesden:

> "The following additions were made on 7 October 2019 following receipt of further responses from [the medical centre] and [Dr C]:
>
> 11. Additional clinical notes provided: EUA findings on 19 June 2019 (a DHB radiation oncologist) showed *a large cervical tumour eroding the whole cervix and most prominently eroding the anterior vagina by more than 50% … it was almost around 6cm in length, and there was only 4cm left of her vagina which was free of the disease.* This was very extensive disease and as discussed in section 8, even though it was by now nine months since the speculum examination documented by [Dr C] it appears quite likely that adequate visualization of the cervix and upper vagina in September 2018 might have shown some macroscopic abnormality[1], and this could raise some concern regarding the adequacy of [Dr C's] examination of [Mrs A] at this time (and see s 13).
>
> 12. Response from [the medical centre] with supporting documentation:
>
> (i) The response notes the cited Map of Medicine Pathway is not currently maintained by the DHB or linked to current PMS. I have used the cited material to represent what would be regarded as accepted practice in the management of PMB whether or not the pathway is commonly used or currently maintained. I would expect a GP to have a working knowledge of accepted management of PMB whether this knowledge was obtained from an accessible localized electronic heath pathway or from some other reputable source of clinical information or education.
>
> (ii) The response outlines measures taken since concerns regarding [Dr C's] clinical competence were first raised prior to the receipt of this complaint. The practice has taken what appears to be a prompt, conscientious and appropriate response to these concerns with patient safety a paramount consideration. It is difficult to see what other steps the practice might have taken prior to potential competency issues being raised, to detect the concerns later identified. The practice repeat prescribing policy is robust but was evidently not being adhered to consistently by [Dr C]. Auditing of compliance with recertification requirements (including professional development) is the responsibility of the Medical Council noting [Dr C] was not vocationally registered.
>
> 13. [Dr C] includes the following new information in his response:
>
> At review on 26 September 2018 [Mrs A's] urethral caruncle appeared to have resolved with use of the oestrogen cream, her vaginal discharge had stopped and there was no further bleeding. On attempted speculum examination, the speculum would not pass beyond the mid-vagina without causing [Mrs A] significant discomfort so the cervix was not viewed. Given the absence of any previous cervical abnormality when [Mrs A] was undergoing cervical screening, and the fact the concerning symptoms appeared to have resolved with disappearance of the caruncle after use of oestrogen cream, [Dr C] felt it was reasonable to defer any further investigation unless

[1] Cosper P et al. Cervical Tumor Volume Doubling Time: A Pilot Study. Rad Oncol. 2015;93(3):e258–e259

[Mrs A] developed recurrence of her bleeding or discharge. When seen for a drivers license medical in January 2019, [Mrs A] denied having any ongoing symptoms of concern and [Dr C] was further reassured by this.

Comment: I remain of the view that accepted practice for investigation of post-menopausal bleeding includes visualization of the cervix and cervical smear and referral for TVUS. [Dr C's] failure to perform these steps represents a significant departure from accepted practice. Taking into account the mitigating factors of concurrent pathology which could explain the symptoms (urethral caruncle), apparent response to oestrogen cream, attempt to undertake speculum examination, and safety-netting advice apparently provided to report recurrence of symptoms, I believe [Dr C's] management of [Mrs A's] condition departed from accepted practice to a moderate degree. As discussed previously, while benign conditions are responsible for around 90% of cases of PMB, those same conditions (predominantly effects of hypo-oestrogenism) can co-exist with malignant causes which forms the rationale for the accepted management recommendations."