Clear patient protocols must be followed to avoid gaps in care

This article considers two recent HDC cases about inadequate assessments and subsequent delays in diagnoses of cancer, which serve as useful reminders of the need to do the basics well.

With millions of consultations every year, GPs constantly consider differential diagnoses, and most care is excellent. However, when essential checks are overlooked, patient care is compromised.

In the first case, a woman went to her medical centre four times over a nine-month period. She was seen by her regular GP three times, and once by a different doctor from the same practice. Initially she presented with perianal itch and irritation, but by the third appointment she had been experiencing intermittent bleeding from her rectum. By the fourth appointment she was experiencing ongoing bleeding from her rectum and a change to her bowel habits.

The woman's regular GP believed she had haemorrhoids and, although he performed a perianal examination at the second appointment, he did not at any time perform an internal rectal examination. The GP told HDC that the woman's anus was very tender, and he thought that an internal examination would be too painful for her. However, there is no record in the clinical notes that an internal examination was discussed with, or offered to, the woman. At her third appointment, the woman saw a different GP and declined an examination. At the fourth appointment, her regular GP again did not carry out an examination and did not record any discussion about an examination. The GP told HDC that he did not conduct an examination because he thought it would be too painful and, as he believed the woman had haemorrhoids, an examination would not change the treatment plan. The woman was diagnosed with rectal cancer two months later.

HDC's clinical adviser on this case said: "As a general rule with any PR bleeding a perianal/rectal examination with internal exam should be done and proctoscopy if indicated for PR bleeding, so that the source of the bleeding is identified. Where the patient declines the exam or it is clinically too painful to perform the exam, a clear plan of treatment outcome expectations should be discussed and review period defined if the PR bleeding or symptoms have not settled."

He also said: "If the internal exam was not done then the reason(s) why should be noted so that there is no confusion over whether it had been performed or not, if consulted by another practitioner … the need for recorded clinical details is important in a group practice setting when more than one practitioner may see each patient."

HDC found that in failing to perform a rectal examination at the fourth appointment, the GP did not provide services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code. The Commissioner also expressed concern that the GP's clinical records were insufficiently detailed.

In the second case, a man's PSA tests showed slightly elevated results. His GP told him that his prostate levels were slightly above normal but seemed stable, that the GP could arrange specialist review if there were any urinary problems, and that otherwise his PSA levels needed to be tested 6–12 monthly. However, the GP did not set a recall for the testing to be done.

The man later requested repeat prescriptions, using an online tool that the medical practice had just started using. At that time, the practice had not recognised how easily patients were able to request

prescriptions without having a face-to-face consultation. The GP requested blood tests for the man approximately a year after the elevated PSA tests, but did not include a PSA test, and the GP told the man by email that he would not need PSA testing for another year.

Some 20 months after the first tests were done, the man saw his GP with urinary retention, and was later diagnosed with prostate cancer. HDC found that the GP failed to meet his obligation to ensure the man's PSA levels were managed appropriately, and that the medical centre did not have adequate processes in place to alert clinicians that the man was due for a PSA test.

HDC's clinical advice was that in "… a group practice with a number of doctors and patients being free to attend any doctor of their choosing, clear protocols are required to ensure that there are not gaps in patients' ongoing care … When repeat scripts are requested [practices should ensure] that there is a system in place to check that all tests and follow-ups that are due are attended to."

While the details of the two cases differ, they both point to a need to do the basics well.

Our data shows that delayed diagnosis of cancer in primary care is an area of concern, and the findings and recommendations in our 2015 report on the issue remain relevant. In it we suggested that there was an opportunity to focus on:

- undertaking clinically indicated examinations and tests;
- examining patients in the context of their past history;
- ensuring comprehensive documentation is kept;
- being aware of the limitations of diagnostic testing (eg, false negative rates);
- considering all clinically relevant differential diagnoses;
- continuing to hold a suspicion for cancer despite co-morbidities;
- not treating symptoms in isolation;
- providing safety-netting advice to patients;
- having robust follow-up systems; and
- advocating for patients in the secondary care system.

The two cases discussed here underscore the importance of these recommendations.

Differential diagnosis is the 'bread and butter' work of primary care. While having a complaint made about you as an individual can be stressful, every complaint is an opportunity to improve.

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