HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Missed opportunities for gastroenterology referral by general practitioner

Executive summary

1. On 12 November 2022, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the care provided to her friend, Ms B.

2. Ms B had presented to general practitioner (GP) Dr C at her local medical centre on a number of occasions with a history of gastric symptoms. When Ms B's symptoms continued to worsen, Dr C did not refer her for specialist gastroenterology treatment, and she was subsequently diagnosed with stomach cancer. This investigation focuses on Ms B's delayed diagnosis of stomach cancer due to these missed opportunities to make a gastroenterology referral. Sadly, Ms B passed away in early May 2023, and I offer my sincere condolences to her family and loved ones.

3. Due to the number of opportunities Dr C missed to refer Ms B to the gastroenterology service at Health New Zealand | Te Whatu Ora (Health NZ), I find Dr C in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for not providing services to Ms B with reasonable care and skill. I have also made an educational comment regarding Dr C's communication with patients.

4. I have made educational comments about the processes in place at the medical centre to support continuity of care and encouraged it to reflect on the support it provides to junior doctors.

Recommendations

Dr C

5. Dr C advised that she has made the following changes to her practice since these events:

   a. She is now careful to ask patients during consultations about any relevant investigations that have been undertaken, and she now sources any related reports when relevant.

   b. When red flags are present, she compares any earlier available recordings of this symptom. If these are not available or not reassuring, she now has a low threshold for referral.

   c. She now completes urgent referrals, and referrals for issues causing particular concern to the patient, while the patient is present.

   d. She no longer waits for ultrasound reports, and sometimes not blood results either, before making referrals, particularly if she is very concerned about the patient. She also makes a referral if a patient reports weight loss where there has been no weight recorded over the last six months.

   e. She takes care to explain at the end of each consultation what the planned next steps are and what she expects the patient to do, including advising them to return if investigations are delayed or not completed or if symptoms change. She also advises

patients to contact the practice if they have not heard back following an urgent referral. Dr C said she also checks that the patient accepts the plan discussed.

f. For *Helicobacter pylori* (*H. pylori*)[1] treatment, she has adopted a more formal and purposeful approach, including explaining to patients that a test for cure will be arranged if symptoms persist.

6. Taking into account these changes, the mitigating factors identified in the report, and that Dr C has since completed her General Practitioner Education Programme (GPEP) training,[2] I make the following recommendations in respect of Dr C:

a. provide a written apology to Mrs A and Ms B's family for the breach of Right 4(1) of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Ms B's family, within three weeks of the date of this report;

b. complete the Professional Development Training course 'Managing Difficult Conversations,' and provide evidence of completion within three months of the date of this report.

The medical centre

7. The medical centre advised that it has made the following changes since these events:

a. reinforced with staff the expectations around clearly documenting all patient contacts;

b. implemented a system for logging follow-up consultations that have been requested or recommended to allow for tracking and staff accountability;

c. introduced a new healthcare assistant pre-consultation screening process where patient weight is checked at each visit. Significant weight loss or gain is flagged for clinical attention to help clinicians prioritise key issues during increasingly time-pressured consultations;

d. created dedicated reserved consultation slots each day with all GPs to accommodate urgent follow-ups or red flag reviews. These are regularly reviewed to ensure access aligns with clinical demand;

e. initiated weekly clinical meetings focused on diagnostic challenges, difficult consultations, and patients who require coordinated follow-up to support improved communication and peer oversight across the clinical team;

f. advocated for better integration of hospital records so GPs can more easily access them and made improvements to its own workflow and communication to minimise these barriers.

8. I acknowledge and support these changes and recommend that the medical centre provides a copy of any new or updated standard operating procedure related to the system

[1] A type of bacteria that infects the stomach lining and is associated with various gastrointestinal issues.

[2] A three-year specialist training programme for doctors to achieve vocational registration in general practice. In years two and three, doctors work in a practice under the guidance of a College Fellow who supports them to extend their learning and reflect on their clinical training.

implemented for logging follow-up consultations that have been requested or recommended. This is to be sent to HDC within three months of the date of this report.

Background

9. Ms B, aged 58 years at the time of the events, had a history of gastric symptoms over several years, including previous investigations for loose bowel motions, which had been successfully managed with omeprazole (an antacid used to neutralise stomach acid).

Initial consultation – 14 January 2022

10. On 14 January 2022, Ms B had her first consultation with Dr C at the medical centre. Dr C was not Ms B's regular GP, and this was her first consultation with Ms B. At the time, Dr C was in her second year of her GPEP training. The clinical records note that Ms B had a history of gastroenterology symptoms over a number of years and that they had been successfully treated with antacids. Ms B is documented to have been experiencing nausea, stomach cramps, and exhaustion in the previous three to four months. It is also documented that she had followed a keto diet (a low-carbohydrate, high-fat diet) for the past six months but that her weight had continued to decline despite having stopped this diet. Her weight was recorded as 73.1kg, 8.4kg lower than in July 2021. Ms B was also reported to have been experiencing variable bowel habits (constipation and diarrhoea), but no blood had been observed in her stool. Dr C recorded that Ms B had anxiety about her mother's death from bowel cancer and recorded her family history of cancer, with her mother having also had breast cancer twice, her sister having died of lung cancer, and her father dying of pancreatic cancer.

11. Dr C sent a referral to a radiology service for an ultrasound, which Ms B did not attend. She also ordered blood tests and a faecal test for *H. pylori*. She documented her plan to send a referral to the gastroenterology service once the results of these tests had been received. Dr C told HDC that she had previously had a referral declined because an ultrasound had not been completed beforehand. As a result, she chose to wait for the ultrasound report before sending the referral to avoid the possibility of the referral being rejected.

12. On 22 January 2022, Dr C reviewed the blood test results, which were normal. She documented the normal blood results but noted that the faecal sample was still needed, as was a further review of Ms B and a referral to gastroenterology. No referral is documented at this time.

13. On 25 January 2022, it is documented that Ms B had asked for another script of omeprazole because of she was experiencing ongoing vomiting, and this was prescribed by a nurse practitioner (NP) at the medical centre.

Positive result for H. pylori – 27 January 2022

14. On 27 January 2022, NP D documented a phone call in which she advised Ms B that her faecal sample was positive for *H. pylori*. Ms B was prescribed triple therapy treatment that included a proton pump inhibitor (medication to reduce stomach acid) and two antibiotics. Ms B was to be reviewed by Dr C in 'a couple of weeks.'

15. Dr C reviewed Ms B on 10 February 2022, after she had completed two weeks of triple therapy treatment. The clinical notes state that Ms B's symptoms had not improved;

however, she had not been taking omeprazole regularly. Dr C advised Ms B to do so and to return to the medical centre for review if her symptoms did not improve.

Care provided between July and September 2022

16. Clinical notes state that Ms B called the medical centre on 28 July 2022, reporting that she needed to see a GP as she had been unwell all year with gut issues and was experiencing weight loss. It is unclear from the clinical notes what action was taken following this phone call or whether this information was relayed to Dr C; however, Ms B was booked for review the following week.

17. On 5 August 2022, Ms B had an in-person consultation with NP D. Ms B reported being sick for months, with loss of appetite, weight loss of nearly 4kg in six months, with her weight now documented as 69.3kg, and thoracic back (upper and mid-back) ache. It is documented that Ms B was experiencing stomach pain that could at times wake her in the night, dizziness and constipation, with no blood in her stool. NP D told HDC that she recalls Ms B feeling like her symptoms were consistent with her previous *H. pylori* infection. NP D's impression was that Ms B was likely experiencing ongoing *H. pylori*, and she documented a plan for a further blood test and a faecal sample, with recommencement of triple therapy treatment once the results were available.

18. On 30 August 2022, Ms B had an urgent care triage phone call with Dr C because of the health issues she had been experiencing 'for a year or two,' which were worsening, and her ongoing abdominal pain. The clinical notes state that Ms B was 'quite distressed,' that she reported further weight loss, constant cramping in her stomach, and that she was now too scared to eat. She also questioned whether the cause of her symptoms was irritable bowel syndrome (IBS)[3] or leaky gut syndrome.[4] Dr C prescribed Buscopan (used to relieve abdominal cramps and spasms), and a follow-up consultation was booked for the following week.

19. Dr C reviewed Ms B on 6 September 2022 and documented that she was experiencing constipation with no proper bowel motion for ten days. Dr C noted that she discussed the ultrasound requested in January 2022 and queried why Ms B had not attended. Ms B is recorded to have said that she had felt good following the triple therapy treatment and thought it was a gastroscopy procedure[5] and so did not have it done. Dr C documented a physical examination of Ms B's abdomen, which was tender and soft, with faecal material throughout the descending colon, where there was also tenderness. Dr C's impression at this consultation was of significant faecal loading[6] and possible IBS, and she queried whether there was another cause for the weight loss. She prescribed Molaxole, a laxative, but undertook no further investigation regarding the weight loss.

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[3] A common gastrointestinal disorder that affects the large intestine and characterised by abdominal pain, bloating, and changes in bowel habits, including diarrhoea and constipation.

[4] Leaky gut syndrome is not currently recognised as a medical diagnosis. It is a proposed digestive condition where the intestinal lining allows bacteria and toxins into the bloodstream, triggering an inflammatory response.

[5] A procedure that allows doctors to examine the upper digestive tract using a flexible tube with a camera inserted through the patient's mouth.

[6] The accumulation of stool in the rectum or lower colon, forming a large mass that cannot be passed naturally.

Referral to the gastroenterology service – 12 September 2022

20. On 12 September 2022, Ms B had a phone consultation with Dr C. The clinical notes record that Ms B had cleared her bowels and the acute abdominal pain had eased but that she was left with a 'knot' feeling in her stomach, was still waking with wind pain in the night, and was very fatigued. Ms B was documented as experiencing some anxiety about her symptoms because of her family history of rectal and bowel cancer.

21. Dr C made a priority 2 – semi-urgent – referral to the gastroenterology service, referencing Ms B's abdominal pain and weight loss. In the referral, Dr C noted that she had requested an ultrasound, which Ms B did not attend, and stated that her impression was of IBS with anxiety but that, because of the weight loss, she was seeking a second opinion.

22. The gastroenterology referral was accepted on 17 September 2022 with a request that a faecal calprotectin[7] test be done. This was arranged by the medical centre, and the results were sent to the local public hospital (Hospital2) on 14 October 2022. The result of 228µg/g indicated abnormal levels of inflammation in the intestines.

Presentations to the local public hospital (Hospital1) Emergency Department – October 2022

23. On 1 October 2022, Ms B self-presented to Hospital1 Emergency Department (ED) because of her worsening symptoms. The discharge summary records that 'GI malignancy' (gastrointestinal cancer) needed to be excluded because of her family history. An outpatient abdominal ultrasound scan was requested, a referral for an endoscopy was completed, and Ms B was advised to await an outpatient gastroenterology consultation.

24. On 25 October 2022, Ms B had an abdominal ultrasound, which reported the presence of a 'markedly abnormal stomach with diffusely thickened wall.'[8] After the ultrasound, Ms B presented to Hospital1 ED because the ultrasound findings meant she required a referral to gastroenterology. An ED doctor contacted the medical centre to request that an urgent consultation be arranged and recommended a referral to gastroenterology. Staff constraints at the medical centre meant that the earliest consultation that could be offered to Ms B was 28 October 2022.

25. Ms B had a consultation with Dr C on 28 October 2022, during which it was documented that she had lost more weight, felt like she had a 'blockage,' and at times was regurgitating when swallowing. Dr C said that Hospital1 had not copied her into the ultrasound results, so she had to access them via the Clinical Workstation (CWS).[9] Dr C said that she explained the findings of the ultrasound scan to Ms B and that the results were concerning for cancer. The clinical notes record that Ms B expressed frustration about how long it had taken to get a diagnosis, noting that she had been unwell for a long time and that she was distressed about the possible implications of the findings. Dr C documented her plan to make an urgent

[7] Faecal calprotectin is a protein released by white blood cells during inflammation in the intestines. Raised levels of the protein indicate intestinal inflammation. The test is measured through a stool sample.
[8] An abnormal thickening of the innermost layer of the stomach wall.
[9] A centralised software platform for healthcare providers to access, manage, and document patient information.

referral to gastroenterology, to upgrade the priority for a gastroscopy, and to arrange a follow-up consultation.

26. Mrs A told HDC that Ms B recalled Dr C saying that the scan showed a thickness of the stomach lining 'and it's probably cancer.' Dr C disagreed with this statement and said her explanation would have been that, given cancer is the worst-case scenario, they should rule that out first.

27. On 1 November 2022, Ms B presented to the medical centre and asked to see Dr C. Dr C said she was about to take her lunch break but agreed to meet with Ms B. The clinical notes record that Ms B was requesting a referral to a private surgeon for a gastroscopy. Dr C completed the referral, as requested. It is documented that Dr C also asked Ms B how she was managing, and Ms B reported that she was 'doing ok' but was sleeping poorly at times. Ms B requested a further review the following week to discuss her sleep medication. A consultation was scheduled for 11 November 2022.

28. On 3 November 2022, Ms B had her private gastroscopy appointment.

29. On 8 November 2022, Ms B had an upper gastrointestinal endoscopy[10] at Health NZ, which found a non-bleeding gastric ulcer noted to be 'probably malignant.' Biopsies were taken for histology and for *H. pylori* testing.

30. On 9 November 2022, Dr C documented that she had received notification of the endoscopy results, which indicated likely malignancy and that the biopsy results to confirm this were still pending. She noted also that a computed tomography (CT) scan had been requested.

31. On 10 November 2022, Ms B underwent a contrast CT scan of her chest, abdomen, and pelvis. The radiology report records evidence of free fluid in the abdomen, a 'significant nodularity'[11] in the tissue connecting the stomach and the liver, and at least three nodules in the right lower lobe of the lung, suggestive of metastases.

Consultation – 11 November 2022

32. On 11 November 2022, Ms B and her support person, Mrs A, attended a consultation with Dr C. The clinical notes document that this was a 'really difficult consult for [Dr C]' as Ms B wanted to know the results of her recent CT scan and whether the biopsy results were available. Dr C explained to Ms B that she had not received the results of the scan or biopsy yet but that, based on her experience, it took a while for biopsy results to become available. With consent, Dr C accessed the CWS and found the reports were available. Dr C recorded that she felt this 'added to the air of distrust' but that she conveyed the results as outlined in both reports.

33. Dr C documented that Ms B said during the consultation that *H. pylori* can lead to gastric cancer and that Dr C should have known that. The clinical records state that Dr C did not respond to this as she 'did not feel anything [she] said could have improved the situation.'

[10] A minimally invasive procedure to examine the upper gastrointestinal tract, including the oesophagus, stomach, and duodenum.
[11] The presence of one or more nodules, which are a small lump or growth.

Dr C recorded that she explained to Ms B and Mrs A that she is not a surgeon but that she had made a referral to gastroenterology services and that they would be able to discuss the treatment options and next steps, as she did not have the expertise to discuss these matters any further. Dr C recorded that she did not feel able to continue being involved in Ms B's care because she did not feel it was in Ms B's best interests.

34. Dr C told HDC that she accepts and acknowledges that this consultation was far from best practice. She said she had expected it to be a follow-up consultation regarding Ms B's sleep and that she had no experience to draw on in terms of how to navigate such a difficult conversation while also managing her own emotions. She explained that she did not know 'how to be the offender and the comforter at once.' Dr C said she felt that any explanation or condolences would have escalated the already strained situation, so she chose to remain silent. She said that she now understands that this was the wrong approach, and she can see from this complaint the distress that this caused. Dr C said she deeply regrets her lack of understanding and apologised for both the distress caused and the delay in diagnosing Ms B's cancer. Dr C said that the medical centre was dealing with the challenges of COVID-19 at the time and noted the additional strain this created across the healthcare system. She said that, in 2022, the medical centre had only two doctors across 5,500 patients, resulting in high workloads, weekend work, and appointments being double or triple booked at times and that 'it was amongst this turmoil that [she] saw Ms B.'

35. Mrs A told HDC that she believes Dr C's assumption that the results would not be available at this consultation was a failure of care. Mrs A said that Dr C did not offer 'factual information' to any extent and provided no information to Ms B about the type of cancer she had, the care she would require, or any support she could access. Mrs A said that Dr C only advised that the specialist team would be in touch and that there was 'certainly no expression of support or care to [Ms B's] wellbeing.'

36. Ms B was subsequently diagnosed with stage 4 gastric adenocarcinoma.[12] Sadly, she passed away in early May 2023. Again, I offer my sincere condolences to her family and loved ones.

Response to provisional opinion

Ms A

37. Ms A was given an opportunity to comment on the 'Background' section of my provisional opinion.

38. Ms A said that, although nothing can change the chain of events or missed opportunities that affected Ms B's care, the family hope that by openly addressing these issues, positive changes will result and lead to improved care and outcomes for others in the future.

Dr C

39. Dr C was given an opportunity to comment on relevant sections of my provisional opinion, and her comments have been incorporated into the report where relevant.

[12] Advanced stomach cancer that has spread to distant organs or lymph nodes, making it generally incurable.

40. Dr C stated that, in the current medical age, patient care involves supporting individuals to take ownership of their health and that patients ultimately decide whether to proceed with recommended investigations. Dr C said that, as Ms B chose not to proceed with the ultrasound and as she did not receive an ultrasound result, she did not complete a referral to the Gastroenterology Department. Dr C further stated that, where patients are provided with relevant information and an opportunity to ask questions or challenge the proposed course of action and they do not voice concerns, it is not reasonable to expect that GPs will follow-up at a later, unplanned time to query why the investigation was not undertaken or challenge their right to choose not to proceed.

41. Dr C said that both she and the medical centre have made changes to their practice since the events to improve the care provided to their community. She said that they strive to continually improve the care they provide within existing time and funding constraints.

The medical centre

42. The medical centre was given an opportunity to comment on my provisional opinion and advised it has no further comments to make.

Analysis

Dr C

43. As a healthcare provider, Dr C is responsible for providing services in accordance with the Code. In reaching this decision, I have considered in-house clinical advice from GP Dr Fiona Whitworth (**Appendix A**).

<u>Delayed referral to gastroenterology service – breach</u>

44. Between 14 January and 11 November 2022, Dr C saw Ms B several times because of ongoing complaints of abdominal pain, gastric issues, and weight loss, as detailed above. Dr C first identified the possible need for a referral to the gastroenterology service on 14 January 2022. A further four consultations took place where Dr C had the opportunity to make the referral, but she did not do so until 12 September 2022, a delay of approximately eight months.

45. In her advice, Dr Whitworth identified the following departures in the care provided by Dr C:

- A moderate departure for the 14 January 2022 consultation: Dr C identified the need for a gastroscopy referral but did not make the referral. In addition, a further mild to moderate departure is noted if no task reminder was set to ensure the referral was completed once the blood results had returned.
- A moderate departure on 22 January 2022: Although the blood tests were reviewed and annotated and 'gastro referral' was again noted, a referral was still not sent.
- A moderate departure overall for the further missed opportunities to make a referral on 10 February 2022, 30 August 2022, and 6 September 2022.
- A mild to moderate departure because the gastroenterology referral sent on 13 September 2022 did not state there was a high suspicion of cancer, given the clinical context.

46. I accept the advice of Dr Whitworth and agree that Dr C missed several opportunities to refer Ms B to gastroenterology services. Although Dr C appropriately acknowledged Ms B's ongoing symptoms and weight loss, no referral was made until 12 September 2022, despite numerous consultations where the need for a referral was documented. Noting also the presence of red flag symptoms that Ms B had been presenting with, including unexplained weight loss, abdominal pain, and persistent changes in bowel habits, and in the context of her family history of cancer, I find this lack of action unacceptable.

47. I acknowledge a number of mitigating factors at the time of the events, namely that Dr C was still completing her GPEP training, was working at a clinic with a limited number of doctors/NPs (meaning workloads were high), and was also navigating the challenges of the COVID-19 pandemic.

48. I also acknowledge that Dr C was awaiting the ultrasound report before sending the referral and that Ms B chose not to attend the ultrasound appointment. Dr C has stated that it was Ms B's decision whether to proceed with investigations or treatment and that it was not her responsibility to follow up on why the ultrasound had not been completed.

49. Although I acknowledge that Ms B had the right to decline the ultrasound, and that it was ultimately her choice not to proceed following the initial referral on 14 January 2022, I do not consider that this absolves Dr C of responsibility for Ms B's ongoing care. In the circumstances where a patient represents with persistent symptoms, it is essential to revisit the need for the investigation, explore reasons for non-attendance, and ensure the decision is made on an informed basis.

50. As Ms B contacted the practice several times after the ultrasound was requested, including two consultations with Dr C (an in-person consultation on 10 February 2022 and a phone consult on 30 August 2022), and continued to report the same concerns and symptoms, I do not accept Dr C's reasoning. I consider that both consultations presented opportunities for Dr C to discuss the ultrasound with Ms B. This did not occur until the consultation on 6 September 2022. In the absence of this follow-up, I do not consider that reliance on Ms B's autonomy is sufficient to justify the lack of further investigation.

51. Therefore, because of the number of instances where Dr C failed to make the appropriate referral and considering Dr Whitworth's advice, I find the cumulative effect of these failures amounts to a breach of Right 4(1) of the Code.

<u>Communication – educational comment</u>

52. Mrs A also raised concerns about Dr C's communication with Ms B, particularly during the consultations on 28 October 2022 and 11 November 2022.

53. Ms B recalled that, at the 28 October 2022 consultation, Dr C told her that, based on the results of her ultrasound scan, her diagnosis was 'probably cancer.' Dr C disagrees with this account. These differing accounts mean I am unable to make a factual finding on exactly what Dr C said at this consultation.

54. At the 11 November 2022 consultation, Mrs A raised concerns that Dr C was unaware of the biopsy results at the beginning of the consultation and with the manner in which she

communicated these results to Ms B. Mrs A said she found Dr C to be unprofessional, uncaring, and to have provided insufficient information about the diagnosis and next steps.

55. Dr Whitworth identified a mild departure in relation to Dr C not arranging to obtain Ms B's consent and access the test results from the CSW before this 11 November 2022 consultation and thought that this contributed to the significant breakdown in communication. Dr Whitworth acknowledged that obtaining test results in front of a patient and having to read and process the information in front of them is difficult and in this case led to a 'dysfunctional consultation.'

56. I agree with Dr Whitworth's remarks. It is evident that there was a breakdown in communication at the 11 November 2022 consultation and that this was a challenging consultation for both Ms B and Dr C, as evidenced in the clinical notes. I agree that it would have been more appropriate for Dr C to have obtained consent to access the results before the consultation given that she was aware these further investigations had been done.

57. This was clearly a very difficult consultation for Dr C, and she has accepted that her management of it was far from best practice. Acknowledging that Dr C was still undergoing her GPEP training and lacked experience at this time, I encourage her to reflect on these events and use the learnings to improve her communication with patients in the future.

The medical centre

Standard of care – educational comment

58. Dr Whitworth advised that, in relation to the consultation of 5 August 2022, there was a mild to moderate departure for the assumption that the *H. pylori* infection was not fully treated without ordering a repeat *H. pylori* test. Dr Whitworth also noted that no test of cure had been arranged at eight weeks after the *H. pylori* treatment.

59. I accept this advice, and I encourage the medical centre to reflect on best practice for the treatment of *H. pylori* infection and ensure that this expectation is clearly communicated to all staff.

60. Dr Whitworth also noted a mild departure if, following Ms B's 27 January 2022 phone call and 5 August 2022 consultation with NP D, there was no discussion between NP D and Dr C regarding these consultations. Dr Whitworth further stated that this was another missed opportunity for a gastroenterology referral to be made. I note that there is no clinical documentation of any discussion, and without this it is difficult to know exactly what, if any, discussions took place. It is the medical centre's responsibility to ensure robust systems are in place to ensure continuity of care, and I note that relevant changes have been made in response to the learnings from these events.

Support for junior doctors – educational comment

61. At the time of the events, the medical centre was managing staffing shortages and the broader challenges of the COVID-19 pandemic. However, despite these external pressures, the medical centre remained responsible for ensuring that junior doctors undergoing vocational training received adequate support and guidance, acknowledging that they are still in the learning stages of practice. I note that the medical centre has reflected on these

events and the adequacy of the support they provided in this case and has expressed its ongoing focus on improving its systems and supporting its clinicians.

Conclusion

62. For the reasons outlined above, I consider that Dr C did not provide services to Ms B with reasonable care and skill in relation to the delayed referral to gastroenterology. Accordingly, I find Dr C in breach of Right 4(1).

63. I also make an educational comment regarding Dr C's standard of communication and educational comments in relation to the standard of care provided by the medical centre to Ms B and its support of junior doctors.

Distribution

64. A copy of the sections of this report that relate to Dr C will be sent to the Medical Council of New Zealand.

65. A copy of this report with details identifying the parties removed, except the expert advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from Dr Fiona Whitworth, General Practitioner:

'My name is Fiona Whitworth. I am a graduate of Oxford University Medical School, and I am a practicing GP. My qualifications are MA 1991, BM BCh 1994, DCH 1996, DCRCOG 1996, MRCGP 1999, PGCMed Ed 2011, FRNZCGP 2013, PGDip GP 2016, and FAEG 2020. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Dr [C] and colleagues at [the] medical centre. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Documents reviewed

14/11/2022	Complaint from Mrs [A]
14/11/2022	Email sent by Mrs [A] to Dr […]
24/11/2022	Phone call documentation
6/12/2022	[Hospital2] DHB Clinical records
12/1/2023	[The] medical centre S14 response and clinical records
1/6/2023	Email from Mrs [A]

Complaint

I have reviewed the complaint. As far as I can determine, Ms [A] has complained about the standard of communication and care provided to her friend Ms [B]. This pertains to two consultations, 4 and 11 November 2022, in addition to the clinical care given in the preceding 18 months.

Ms [A] requests answers to the following:

- Why did Dr [C] take so long to instigate an endoscopy, biopsy, CT scan to investigate [Ms B]'s continued ill health and weight loss.
- Why had Dr [C] not read and have a comprehensive understanding of [Ms B]'s results and be able to discuss these with [Ms B].
- Why did Dr [C] not ask about [Ms B]'s state of physical, mental, and emotional health, especially at her last consultation.
- Why did Dr [C] say to [Ms B] during a phone consultation "I don't know what is wrong with you, I don't know everything, Google it."
- There have also been scripts given that were specifically not wanted, wrong scripts sent, and delays in sending a referral.

Clinical Timeline with Comment

2/8/2013	Omeprazole 20mg 1/12
30/4/2015	Omeprazole 20mg prescribed
29/6/2016	Colonoscopy abn [abnormal] – two polyps – on five-yearly surveillance
302/5/2019	Omeprazole prescribed 20mg 3/12

12/1/2021 **GP consultation by […] (Dr […])**
'Takes omeprazole PRN this is a long term rx from previous GP no red flag symptoms of dysphagia wt loss etc and used PRN only'
Omeprazole 20 mg prescribed.

16/4/21 Phone triage […]
'Some wind and belching worse when tummy is empty indigestion tablets have not helped Bowels ok P. IP review today'

16/4/21 **GP consultation in person […]**
'Abdo/gastric discomfort – last 4–5/7 has been noticing frequent, intermittent abdo cramps/tightness
- associated with belching. Symptoms improved with milkshake or eating
- as bad as a 7/10, and is pain free between episodes
- No hx of liver/gallbladder issues. No other meds; however, took x1 course of NSAIDs which precipitated this event
No diarrhoea, no blood in stools
Imp: crampy abdo pain ?gastritis
Plan:
Bloods to rule out hepatobiliary causes
- also due CVD bloods 2/52 course of high-dose omeprazole
- avoid NSAIDs and use paracetamol for pain relief
- PRN acidex as needed
Return if symptoms are ongoing or worsen'

Blood tests were normal

Comment
This plan of action was appropriate, and follow-up was planned if needed. It is reassuring that the blood tests were normal. It is clear that there were prior gastric problems that had been treated previously intermittently with acid-lowering medications. It is not clear who KF is from the notes provided. There were further unrelated consultations, at which there was no discussion/review of abdominal symptoms.

16/4/21 Wound review

23/4/21 Suture removal

11/5/21 Stitch removal

24/6/21 COVID assessment

14/1/2022 **On triage list […]**
'Said has been feeling unwell for the past month, gastric issues with her stomach, said has been losing weight [a stone and ½ in the past 6–12 months, not feeling like eating, tired, said is impacting on her life, booked for review with dr today'

14/1/2022 **GP consultation in person Dr [C]**
'Not feeling well
Gastro problems for years
Previous loose BM, previously investigated
Went with antacids
Seemed to be ok

(?April)
Over last 6 months
Has been on keto diet
Feels weight is still reducing in spite of stopping keto diet
Now nauseated a lot with stomach cramps
Occ vomiting after food
Can't drink EtOH = dry retching and nausea
Now too scared to eat because of stomach cramps
Now prefers gingernuts, ice-cream, sushi, eggs
Sometimes a cup of tea in the morning might set it off
Nauseated at times from waking
Feeling tired, exhausted
Other days ok
Bowel habit variable
Sometimes constipated, loose, normal
Normal = formed motion 2–3x/week
Loose = loose – not watery with urgency
Not floating
No blood, brown, not black
Passing BM does relieve pain momentarily
No jaundice
Going on for months 3–4 months
Has been using probiotics
Avoiding acid foods
Eating fermenting foods
Omeprazole and acidex prescribed.
Weight 73.1kg
Examination
Abdomen soft
Tender epigastrium and RUQ
Some tenderness RUQ on deep insp but not clearly Murphy's positive
No percussion tenderness
Imp:
?gallstones, ?GUD ?DUD ?IBS ?Coeliac
Plan:
1 USS abdo
2 Gastroscopy request following bloods
3 Bloods
4 Omeprazole
5 Faecal H. pylori
6 RV post results or earlier if symptoms deteriorating'

Comment

The GP has taken a thorough history as is advised.[1]

[1] https://midland.communityhealthpathways.org/24341.htm Accessed 27/8/2023.

However, this is a significant weight loss. I am moderately concerned that, although the GP did identify the need for referral for gastroscopy at this [time] did not actually send the referral as per her plan as documented on receipt of the blood results. It is possible that she did not set herself a task to remind herself to do this. It is accepted good practice to set a reminder to complete planned referrals if they cannot be done immediately (e.g., if dependent on blood results).

It is appropriate that an initial ultrasound was sent as she states that she wished to investigate for gallstones.

Testing with blood and faecal *H. pylori* testing is also consistent with best practice (1). The plan states to have review after results – this did not occur. It is not clear if a task was made to remind the GP to ask the patient to attend if the patient did not come in of her own volition.

14/1/2022 **Blood results normal**
FBC normal, Coeliac normal, Haematinics normal, LFTs normal

17/1/2022 **Ultrasound request acknowledged by hospital**

22/1/2022 Dr [C] reviewed blood results: normal. Considered starting PPI [proton pump inhibitors] and FODMAP [**F**ermentable **O**ligosaccharides, **D**isaccharides, **M**onosaccharides, and **P**olyols] diet.
Clinical code of GORD [gastro-oesophageal reflux disease] added to record.
Notes
'Bloods OK
Needs RV
PPIs?
FODMAP
Needs Faecal H. pylori and faecal calprotectin
Gastro referral'

Comment
It appears from this entry that the GP again thought about referring, but this was not done. It is also stated that she needed to come in for review. It is not clear what information was sent to the patient at this stage other than a text on 25/1/22 to say a script was ready.

I am moderately concerned that the referral was not done at this stage – this was a missed opportunity.

25/1/22 **Entry by […]**
'Vomited after sultana bran & milk. On omeprazole for 1/52, which helped. Awaiting stool sample lab results.
Asks if can have another script for omeprazole. Has a consultation for review with […] on 10 Feb
Omeprazole 40mg prescribed by NP – TAC'

Comment

It is not clear who […] is or whether this request was passed on to Dr [C].

27/1/2022 **Phone call to patient by NP [D]**
'+positive H. pylori
Plan:
1 Commence treatment
2 Review as planned with Dr [C] in a couple of weeks' time.'

Comment
Follow-up arranged, which was appropriate. Ms [B] had a *H. pylori*-positive stool test – given appropriate triple therapy – seven days of treatment given.

This was another missed opportunity to refer. Ms [B] at this stage was positive for *H. pylori* with gastric symptoms and weight loss and pain over the age 50 (1).

The planned review was in 14 days – again feel that this introduced another delay in her treatment pathway.

10/2/22 **GP consultation in person Dr [C]**
'Symptoms have not improved
Has completed two-week H. pylori eradication
Feels better when takes omeprazole but not taking regularly
Improved previously following taking Losec
Plan:
1 Take Losec
2 RV if not improving
3 Faecal calprotectin not done, seems ok to hold off for now'

Comment
This was a missed opportunity to send the previously planned referral to gastroenterology.
No test of cure arranged for patient re *H. pylori*.

28/7/2022 **Phone call by […] replying to pt request for a call**
'Needs to see GP reports has been unwell all year with gut issues, losing weight'

Comment
It is not clear who […] is, and it is not clear what the action was; however, I note the patient was seen next in August. There is a lack of continuity of care. It would have been more appropriate if Ms [B] had been seen by her GP.

5/8/2022 **NP in-person consultation [NPD].**
'Reports being sick for months, months
Saw Dr […] in Jan
Treated for H. pylori – did feel good now deteriorated again.
Now small meals, loss of appetite
Losing weight she feels constant feeling of getting period, thoracic back ache.
Seen naturopath – coming up with a plan

Just started Floradix
O/E:
Looks well
Describes lots of belching
Not really bloating
Bordering constipation if anything
Not as regular as used to be, though diet not to par currently
No blood in stool
Pain in stomach can wake her in the night
Pain during the day
Drink of water will make cramping come on.
Some dizziness
WT 69.3 (nearly 4kg in six months)
Imp:
Likely ongoing H. pylori
Plan
1 Pathology review
2 Recommence BD [twice-daily] PPI once sample given'

Bloods tests were normal.

Comment

No test of cure was arranged at eight weeks after the initial treatment for *H. pylori*. I am mildly to moderately concerned that the NP is assuming that *H. pylori* was not fully treated, and although she has ordered bloods (normal), she has not ordered a repeat *H. pylori* test. No abdominal examination was undertaken – this would have been good practice. If the full clinical history had been examined, she may have picked up that a referral was outstanding.

26/8/2022 Minor surgery removal of skin lesion.

30/8/2022 **Urgent care triage phone call – Dr [C]**
'Health issues for a year or 2, getting worse, not better
Ongoing abdominal pain
Wondering currently about IBS/leaky gut
Has been Google searching
Feels meets the criteria
Changed diet yesterday
Is losing more weight
Really quite distressed
Cramping in stomach is constant
Too scared to eat
Doesn't feel anxiety is contributory
Although admits to anxiety at times
Plan:
1 Try Buscopan

2 RV next week'

Comment
I am again mildly to moderately critical that a referral was not done. Weight loss noted and no referral done, although review arranged.

6/9/2022 **On triage list […]**
'Said that can't eat, losing weight, constant abdominal pain
Not happy that can't get to see dr
Booked UC ip with dr today'

6/9/2022**GP consultation in person: Dr [C]**
'Bad night last night
Gaviscon and sat up
Too scared to take anything so didn't take Buscopan until quite late
No diarrhoea currently
More constipated if anything
Small motion this morning, soft
No motion for 10 days
Previously daily eating kiwifruit and prunes
Since last week, stopped smoking, stopped coffee, sugar and gluten
Starts the day with porridge, probiotic yoghurt, prunes and rhubarb
Smoothie – banana and blueberries
Seeing homeopath – on Vit B
I requested an USS in Jan ?what happened to this
DW [Ms B] – says felt really good after having H. pylori eradication, this with thinking it was a gastroscopy and not wanting this, = didn't have it done
Abdomen tender, soft
?faecal material throughout descending colon – tender here
BS normal active
Weight 66.8kg
Imp:
1 Significant faecal loading
2 ?IBs
3 ?other cause for weight loss'

Comment
GP has assessed as constipation appropriately then treated but has not gone on to further investigate the weight loss at this point, despite her plan. She has correctly picked up that the ultrasound was not done and explored reasons around this.

The referral for a gastroscopy was again not requested.

12/9/2022 **Telephone consult Dr [C]**
'"I'm ok"
Cleared bowels out
Has had diarrhoea yesterday and today
Acute abdominal pain has eased

Is left with some knot feeling in stomach
Still waking during the night with wind-type pain
Fatigued ++
Better day today
Is forcing self to eat something, trying to keep with things that agree with her, trying FODMAP, off gluten and coffee"

Comment
GP has now referred to gastroenterology – semi-urgent – priority 2 waiting list. The referral has now been made, but it is unclear from the notes what she feels the problem is. The consult has covered some mental health issues at this point as well.

13/9/2022 **Gastroenterology referral –** Semi-urgent
'Her abdominal pain and weight loss this year (6kg since Jan). I requested an USS, which she DNA'd because her symptoms improved. I do think this is probably IBS with anxiety, but given her weight loss wanted to run her by you. She initially was H. pylori positive and feels her symptoms improved after treatment, but subsequently recurred.'

Comment
I am mildly to moderately critical that this was not sent stating a high suspicion of cancer. The GP states that she felt the diagnosis was of IBS but wanted a second opinion.

17/9/2022 **Accepted gastroenterology – priority 2** for faecal calprotectin

30/9/2022 Calprotectin faeces – 228

1/10/2022 **[Hospital2] discharge**
PC [post cibum, meaning 'after meals'] epigastric pain and early satiety, altered bowel habit. Examination unremarkable. Bloods were normal.
Imp GI malignancy needs exclusion.
Plan abdo ultrasound with copy to GP/opd [Outpatient Department] gastroenterology (16/11/2022)/referred endoscopy

Comment
The conclusions reached are appropriate and the referrals were made. However, it appeared that the result of the ultrasound did not reach the GP practice despite the plan to do this by the hospital.

I am mildly critical of this breakdown in communication.

14/10/2022 **Gastroenterology referral – advice only**
This was done to update the department with faecal calprotectin result.

25/10/2022 **Abdo ultrasound ordered Dr […]**
Of note is the presence of a markedly abnormal stomach with diffusely thickened wall?
Related to gastritis versus neoplastic.
Gastroenterology referral recommended.

25/10/2022 **Nursing staff at [the] medical centre**
Nursing staff received a phone call from ED Dr […] at [Hospital1] asking for urgent appointment with Ms [B] to be scheduled as ultrasound results had come in. The next consultation was 28/10/22.
'Has had [Ms B] arrive in ED following USS – Radiologist says gastric mass –
needs work up and referral to GI. Have checked with WC – we do not have capacity to do this until Friday as staffing issues.
Have explained this to Dr […], who is under similar pressure at his end.
He will offer Friday consultation to [Ms B] (reminder to myself to check if coming on Friday) or wait in ED until he can get things sorted there.
I have explained that we require all reports ASAP to be able to do referral.'

28/10/22 **GP consultation in person: Dr [C]**
GP met with Ms [B]. GP states did not have the ultrasound results, so these were accessed through the CWS at hospital. GP states:
'I explained the findings of the ultrasound scan and that this was concerning for cancer. Ms [B] was then very angry with me, annoyed at how long it had taken to reach a diagnosis, and annoyed that investigations were not requested sooner. I reviewed the notes with Ms [B], explaining that she had not gone for an ultrasound as requested at the beginning of the year, and had not re-presented for over 6 months.'
Notes:
'Recent USS showing gastric thickening
Available on CWS
Lost more weight
Weight 62.5kg
Feels like a blockage
Occ will be able to swallow, at other times will have a regurgitation
Really annoyed about how long has taken to get a diagnosis
Annoyed because was unwell for a long time and we haven't gotten onto things faster Have RV'd notes with [Ms B]
Initially seen back in Jan and requested USS at that time
Did not have an USS because initially felt a little better
Seen again in Feb and then did not see [Ms B] again until August
Understandably really distressed about possible implications of findings and annoyed about having taken this long for something definitive.
Plan:
1 Urgent referral to Gastro for upgrading of priority for gastroscopy and follow-up'

"The complaint quotes me as saying, "Also on Friday 4th November, [Ms B] saw Dr [C] and she said; "In the scan they saw a thickness of the stomach lining and it's probably cancer." (I think she is referring to this consultation). I do not agree with this statement. My explanation would have been along the lines of, "given cancer is the worst-case scenario, let us rule this out first.""

Comment
It appears from the notes that the ultrasound report had not been sent through to the practice as planned by the ED. It was their responsibility to do this, as they had wanted the

GP to be able to act on the results. However, from the notes and the call from ED [Hospital1], it was clear that the patient was coming in re the ultrasound, and good practice would have been to obtain the result (with patient consent) prior to the consultation so that the GP could have read this and formed a plan of action. It appears from the notes and letter of explanation from the GP that an attempt was made to discuss the delay in referral to the patient at this consultation.

The notes do not state what the patient was told. An improvement would be to document this so that subsequent colleagues would be aware of what the patient had been told. There is some contention with what was said in the complaint – I cannot comment whose version is an accurate representation of events.

28/10/22 **Gastroenterology Referral –** High suspicion of cancer – Accept priority 1 – Gastroscopy
NB/patient has an outpatient booking and is on waitlist for UGI [upper gastrointestinal] + colon B1. We will cancel these other referrals and just do HSCAN gastroscopy in first instance. Further investigation can be arranged if necessary thereafter.
'Recent USS showing thickened stomach – I don't have report – is on CWS.
Has OP appt with gastro
Please for urgent gastroscopy and FU'

31/10/2022 **Gastroenterology Referral by Dr [C]** High suspicion of cancer
Just wanting to make sure this lady gets picked up and followed up for possible gastric cancer.
Have also referred to Gastro (referred in September).
Please see USS results on CWS and [Hospital1] ED notes.

Comment
The GP has been thorough and has ensured that all parts of the hospital system are aware of the progress of Ms [B]'s clinical course.

1/11/2022 Amendment to hospital discharge from 1/10/22

Dr […] emailed [Hospital1] to expediate OGD from priority 2 to sooner.

1/11/2022 **GP Consultation in person: Dr [C]**
GP letter states patient had walked into the surgery and asked to be seen.
Ms [B] requested a referral to Mr […], Hepatobiliary Surgeon, as she had a consultation booked but just required a referral. At this time, I enquired as to how Ms [B] was managing. She admitted to being ok, having good days and bad days and admitted she had been sleeping poorly at times. She had some sleeping tablets but thought she would run out soon. A further consultation was made for 11 November to discuss this, following the gastroscopy as requested.
Notes
'[Ms B] walked in today
Says has appt booked with [hepatobiliary surgeon] but needs a referral for this
Enquired as to how she was doing
Doing ok, sleeping poorly at times

Wanting further RV end of next week to discuss sleeping
Using something currently but may run out
Appt made for next Friday – following gastroscopy
Specialist referral (Urgent) to Mr [hepatobiliary surgeon]

Comment
The GP has kindly fitted the patient in to be seen and done the referral to the private specialist. She has arranged follow-up as appropriate re sleeping problems identified and also to review after gastroscopy. These are all appropriate.

3/11/2022 **Gastroscopy private: Dr […] [hepatobiliary surgeon]**

8/11/2022 **Upper GI endoscopy: Dr […], [Hospital1] Endoscopy**
'One non-bleeding cratered gastric ulcer with no stigmata of bleeding was found at the gastro-oesophageal junction. Biopsied. Probably malignancy.
Recommendation: – Await pathology results. – Refer to MDM at consultation to be scheduled.'

8/11/2022 – **Histology form**
'GASTRIC BIOPSY: POORLY COHESIVE CARCINOMA WITH SIGNET RING MORPHOLOGY'

8/11/2022 **GP serious notification sheet sent from [Hospital2] to GP** – scanned on 9/11/2022 informing GP of cancer and investigations ordered/completed.

9/11/2022 **GP Practice Dr [C] note**
'I received notification of the endoscopy results, which indicated likely malignancy with biopsy results awaited, and that a CT scan had been requested.'

10/11/22 **CT abdomen/chest/pelvis** ordered by Dr […] [Hospital2] on hospital system only.
'There is evidence of free fluid in the abdomen. Diffuse infiltration of the stomach associated with calcification of the stomach wall. There is significant nodularity of the adjacent omentum and soft tissue at the lesser sac. There is thickening of the gastro-oesophageal junction with blurring of the surrounding soft tissue adjacent to the oesophageal hiatus. Several small lymph nodes are noted in the lesser sac, gastro-oesophageal junction and distal oesophagus. Significant diaphragmatic lymph nodes. There is evidence of nodularity of the omentum in keeping with omental disease. At least three nodules noted in the right lower lobe suggestive of metastases.'

11/11/2022 **GP Comment – Dr [C]**
'Endoscopy = gastric ulcer ?malignant
Awaiting biopsy results
CT scan requested'

Comment
The GP was aware that additional tests were ordered and that potentially there could be results that could be accessed; she states in her notes that these were accessed when she had consent from the patient to do so. An alternative approach would have been to obtain verbal consent from the patient prior to the consultation to access these if available. This

would have allowed the GP to review and process the implications for the patient before the consultation. This would have then allowed improved communication with the patient. I am mildly concerned that this was not the course of action undertaken.

11/11/2022 **GP consultation**
'Questions today
In with support person today
Really difficult consult for me
Consult originally made to discuss [Ms B]'s sleep ?needing sleeping tablets
[Ms B] says sleeping really well currently
Wanting to know the results of her CT which she had on Wednesday and wondering if histology back
Explained I have received nothing
Histology can take a while to come back
Accessed CWS with consent
Both reports available
Unfortunately, this felt like it added to the air of distrust as I said histology can take a while (judging by my GP experience which was not appropriate for hospital/cancer concerns) and they were available
I conveyed the results as outlined in both reports as I was able.
[Ms B] explaining that H. pylori can lead to gastric cancer, and I should have known that "I've told you all along that I had ulcers"
I did not respond to this – I did not feel anything I said could have improved the situation
[Ms B] and support person understandably really unhappy at the end of the consult
"ok so I've got cancer and that's it and see you later, is what you're saying"
I explained that I'm not a surgeon, I have made a referral to upper GI who will discuss what the treatment options are and go from there.
Unfortunately, I do not have that expertise to discuss any further in terms of chemotherapy or what type of operation etc – not yet staged
Explained will have an MDT to discuss this and decide on treatment, they will then talk to [Ms B] about all of this
I have found these consults with [Ms B] very difficult. I do not feel I am able to be involved in her care any further, and I do not feel it is in her best interest for me to provide care for her.
Her support person requested print offs of histology and CT scan, which I have provided from CWS'

In her response letter, Dr [C] states – *'No notification of biopsy results or CT scan had been received … these have never been sent … these were available on CWS system … which we do not access freely and which requires patient consent to do so.' 'On this day, given Ms [B]'s distress, these were accessed.' She also states she had thought the consultation was in regard to follow up of poor sleep …'*

11/11/2022 **Referral to General surgery** – High suspicion of cancer by Dr [C] Thanks for your ongoing care of [Ms B] who has recently had CT and gastroscopy with biopsy
Biopsy and CT results on CWS

Comment
Although the GP may have thought she was coming in for her sleep, at this point the GP also knew that the endoscopy had been done a few days prior, that there had been an abnormality on the ultrasound, and that a CT had been ordered. In consults, there is often a tension between the GP agenda (to review sleep) and the patient's agenda. It is common practice to enquire initially what the patient wishes to address.
I feel it was likely that the patient was going to ask about these results, and the GP could have asked for consent to access these prior to or at the start of the consultation. It is not stated whether these can be printed off. This was not done – in practice, if this had been done it could have been scanned into her GP record, which would have improved future GP care through clinical information being at hand.
There was a significant breakdown in communication regarding how results were handled, with the patient expecting that the hospital would be in contact.
However, it is usual practice for results not to be copied into GP practices at present.
Had the GP had the results she would have been in a better position to frame the consultation rather than looking up and reading very abnormal results in the consultation, which was then difficult for her to process and then impart to the patient. Her choice of not saying much after giving the results was, in her reflection, the wrong choice of consultation tool. She has apologized in her response to the HDC for this choice.
Her detailed notes point to this being a difficult consultation.
After the consultation, she was again conscientious and wrote to the hospital with an update to ensure all departments were aware of Ms [B]'s diagnosis.

11/11/2022 **Referred to MDM** – at the hospital by hospital

16/11/2022 **Letter to GP**
'Diagnosis:
1. Stage 4 gastric adenocarcinoma
Prior to her endoscopy there was the strong possibility of malignancy, and this was discussed pre-procedure. Following the procedure, she was informed that she probably had a gastric cancer as the basis for her symptoms and subsequent investigations have included a histologically proven signet ring adenocarcinoma of her stomach with metastases to omentum, free fluid in the abdomen and multiple lung nodules.'

15/11/2022 **MDM Hospital**
58F. Gastroscopy for 25kg weight loss and early satiety showed large gastric carcinoma. Symptoms for 18 to 24 months.
Biopsy: poorly differentiated carcinoma. Stage 4 gastric carcinoma.
Consider palliative chemotherapy.
Oncology – referral submitted to Med Onc 16/11/22

18/11/2022 Letter to GP from Gastro
'Thanks [Dr C],
We discussed [Ms B] at MDM on Tuesday, and I had the opportunity to meet with her today. She reviewed the results you provided her with on Friday, and so she started today's conversation from a good level of understanding. I confirmed today that she has metastatic adenocarcinoma

of the stomach, and our oncology colleagues offer best therapies in this setting. A referral to oncology is being created internally'

Comment
Although the consultation on 11/11/22 had been difficult for the patient, it appears that, when she was seen at the hospital, the hospital colleague felt it had been helpful for patient understanding.

Other issues raised.
Re statement re googling complaint – "I don't know what is wrong with you. I don't know everything, you'll have to Google it."

GP – *'I do at times admit to patients that I do not know everything, nor do I claim to know all the physiological explanations of someone's symptoms. However, this is always in the context of, "therefore, let us do these tests and refer to the specialist for their advice." In the context of irritable bowel syndrome, I always direct individuals who have symptoms consistent with this to read about this on the Monash University in Australia's website, as this is a robust and user-friendly website for information. I do not ask my patients to look up their symptoms on Google to see what they come up with.'*

This has been answered by the GP; however, it was not what the patient and her friend recollect.

Comment
GPs are specialist generalists and therefore do not [know] everything. It is good practice to be open with patients and acknowledge this and, if appropriate, signpost to additional information available to patients to answer their questions. This appears to have been Dr [C]'s intent from her letter of reply.

<u>Overall discussion of case and clinical advice</u>
A number of issues have been raised by the clinical care provided by the clinical team at the GP practice and hospital.

<u>1 Re delayed referral to gastroenterology</u>.
There were several missed opportunities to send a referral after Dr [C] identified the need in her initial consultation with Ms [B] on 14/1/22. The plan stated was to refer after receipt of blood tests. This was not done, and I am moderately critical of this lack of action. It is unclear if a task was set by Dr [C] to remind her to ensure Ms [B] had come back for review following her tests and to send the referral – if this had not been done, I would be mild to moderately critical of the lack of such action.

There were further clinical contacts when this could have also been done: 27/1/2022, 10/2/22, 5/8/2022, 30/8/2022, 6/9/22.

I am moderately critical of this lack of action.

On 13/9/22, the gastroenterology referral was sent as 'semi-urgent.' I am mildly to moderately critical that this was not sent stating a high suspicion of cancer. The clinical notes do not have a clear differential written in them.

Ms [B] had presented with pain/weight loss and age over 50 – recommended practice[2] would be to send this urgently.[3]

2 *H. pylori* investigation

No test of cure was arranged after diagnosis of *H. pylori* in Jan 2022. I am mildly to moderately concerned that the NP [D] is assuming that *H. pylori* was not fully treated and although ordered bloods (normal) she did not ordered a repeat *H. pylori* test. In addition, no abdominal examination was undertaken at this consultation. Current guidelines would suggest that retesting would have been appropriate.[4]

3 Communication issues

- 1/10/22 ultrasound ordered by [Hospital1] ED. 25/10/22 ultrasound performed; however, no report sent to the GP as planned. I am mildly critical that the ultrasound report was not sent by [Hospital1] ED to the GP as planned.

- It is unclear whether the NP was liaising with Dr [C] after her consultations on 27/1/21 and 5/8/2022. If this did not occur, I would be mildly critical of this lack of continuity of clinical care.

- Obtaining results from the hospital clinical system: Dr [C] states that she needed consent to do this, which is why she did not look prior to the consultations. I am mildly critical that she did not arrange to be able to do this given she had received an urgent notification from the hospital. This would have better prepared her for the consultation. It is impossible for a GP to do this for every result on the clinical system; however, in cases when an urgent notification has been sent by the hospital, I would have expected the report to have been viewed prior to seeing the patient. Obtaining a result in front of a patient, reading it and processing the information is difficult, and this then led to a dysfunctional consultation. This is one of the main aspects of the complaint and could have been avoided if effective preparation had been undertaken.

I do note, however, that Dr [C] was at the early stages of her GP training and would have still needed support and guidance from her GPEP teacher. It is not clear how much support she was receiving at this stage.'

[2] https://midland.communityhealthpathways.org/24341.htm Accessed 28/8/2023
[3] https://bpac.org.nz/2022/h-pylori.aspx#flags Accessed 28/8/2023
[4] https://bpac.org.nz/2022/h-pylori.aspx Accessed 28/8/2023