Diagnosis of rectal cancer
17HDC02317, 26 March 2019

General practitioner ~ Medical centre ~ Examination ~ Rectal cancer ~ Right 4(1)

Over a period of nine months, a woman presented to her medical centre on four separate occasions.

She was seen by her regular general practitioner (GP) for the first two appointments. At the first appointment, she presented with perianal itch and irritation. No examination was performed, and her GP suggested she try Proctosedyl ointment. By the second appointment, the external anal itch had settled, but she had noticed blood on toilet paper after wiping. A perianal examination was performed, and the GP concluded that a haemorrhoid was likely and prescribed suppositories. A digital/internal examination was not performed, as the GP considered that the procedure would be too painful.

The woman attended a third appointment with another GP, as she had been experiencing intermittent bleeding from her rectum but no changes to her bowel habits. The clinical notes record that a rectal examination was declined, and suppositories and anti-nausea medication were prescribed.

The woman attended a fourth appointment with the first GP for ongoing bleeding from her rectum and change to her bowel habits. The GP explained to HDC that no examination was performed as his attempt previously had been too painful for her, and she had declined an examination from the second GP. The GP believed that she had haemorrhoids, and that an examination would not change the treatment plan. He discussed with her a referral to the public hospital and ordered blood tests. After receiving abnormal liver function results, he completed the referral.

The woman was reviewed at the public hospital two months later, where an examination revealed a palpable liver mass and a mass above the anal canal, which was later diagnosed as rectal cancer.

Findings
By 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). The medical centre was not found vicariously liable for the GP's breach of Right 4(1).

Recommendations
It was recommended that the GP provide a written letter of apology to the woman's daughter for the breach of the Code identified, and provide evidence of the learnings from the bowel cancer update he included as part of his Professional Development Plan with the Royal New Zealand College of General Practitioners.