Medical Centre
General Practitioner, Dr B

A Report by the
Health and Disability Commissioner

(Case 18HDC02354)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report primarily concerns the care provided to a man by a general practitioner (GP) at a medical centre.

2. The man consulted the GP following a fall in February 2018. Subsequently, in March 2018, he was seen by the GP for two further consultations about the pain in his general perineal region and also a change of bowel habit. The GP noted that the man had felt pain in his coccyx. The man then had two further consultations about his change of bowel habit, first with a second GP on 24 March 2018, and secondly with a third GP on 3 April 2018. On 5 April 2018, the man had his final consultation with the first GP, and was referred for consideration of a colonoscopy.

3. None of the GPs performed a digital rectal examination (DRE) at any of the consultations. The first GP understood that the man had pain in his coccygeal area and not his rectal area. The GP said that the man did not communicate that he had pain in his rectal area at any of the consultations. In mid-April 2018, the man transferred to another GP, and was subsequently diagnosed with rectal cancer.

4. This report highlights the importance of considering differential diagnoses for a patient's symptoms, and of conducting appropriate tests. It also highlights the importance of ensuring adequate referral from GPs to secondary care services.

Findings summary

5. The Commissioner found the GP in breach of Right 4(1) of the Code. The Commissioner considered that the exact location of the pain was not assessed adequately, and given the man's changing bowel habit, there was a lack of critical thinking about alternative diagnoses. In addition, a DRE was not performed at the consultation on 5 April 2018, and the referral letter on 5 April 2018 was inadequate.

6. The Commissioner also made adverse comments about the care provided by the other GPs. The Commissioner considered that the second GP should have performed a DRE and given more attention to the first GP's note that the man might need a referral for a colonoscopy. Similarly, the Commissioner considered that the third GP's decision not to perform a DRE was unreasonable, and that a wait of three weeks for the man's next review was too long.

7. The medical centre was not found in breach of the Code.

Recommendations

8. The Commissioner recommended that the three GPs apologise to the man's wife and undertake further training on colorectal cancers.

9. The Commissioner recommended that the medical centre report back to HDC regarding the review of its processes as a result of this investigation.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her husband, Mr A (deceased), by Dr B and Medical Centre 1. The following issues were identified for investigation:

- *Whether Medical Centre 1 provided Mr A with an appropriate standard of care in 2018.*
- *Whether Dr B provided Mr A with an appropriate standard of care in 2018.*

11. This report is the opinion of the Commissioner.

12. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer's wife
Medical Centre 1	Medical centre
Dr B	General practitioner
Dr C	General practitioner
Dr D	General practitioner

13. Further information was received from:

Medical Centre 2	Medical centre
Dr E	General practitioner
Dr F	General practitioner

14. Independent clinical advice was obtained from Dr Jim Vause and is included as Appendix A.

Information gathered during investigation

Introduction

15. This report concerns the care Mr A received from Dr B, Dr D, and Dr C at Medical Centre 1 in 2018 when Mr A presented on multiple occasions complaining of pain around his tailbone and a change in bowel habits.

Background

16. Mr A, aged in his eighties in 2018, had been enrolled as a patient with Dr B at Medical Centre 1 for several years. Mr A remained enrolled at Medical Centre 1 until April 2018, when he transferred to Dr F at Medical Centre 2. Medical Centre 1 told HDC that Mr A had a history of constipation, and that from 2010 onwards he made occasional requests for laxatives.

Relevant consultations in 2018

16 February 2018 consultation

17. On 16 February 2018, Mr A suffered a fall at home, and consulted Dr B at Medical Centre 1. Dr B examined Mr A's coccyx (tailbone) area and noted:

> "Fall off step onto tailbone, been sore so taking more paracetamol which has made constipation worse. Otherwise well, keeping active on his property."

18. Dr B prescribed Laxsol[1] for Mr A.

19. Mrs A recollected that Mr A had a fall around 16–17 December 2017, and that he had had "pain in his bottom" since 2016. However, Medical Centre 1 told HDC that Mr A provided the date of the fall as 10 February 2018. This was also documented in the ACC Injury Claim form (subsequently submitted on 19 March 2018).

8 March 2018 consultation

20. On 8 March 2018, Mr A had another consultation with Dr B. The issue of constipation and soreness around Mr A's coccygeal area was discussed again. Dr B examined Mr A's abdomen and noted that there was no distress around the abdominal area. Dr B prescribed lactulose[2] for Mr A and documented in the clinical notes:

> "Constipation still an issue for him. [History] rather difficult but seems laxsol i tab[let] not enough [and] ii cause loose [bowel movements]. No blood seen. Good appetite, no [weight] loss. Coccyx still sore from fall. Had lactulose in the past 2010 — will try that again."

19 March 2018 consultation

21. On 19 March 2018, Mr A had another consultation with Dr B. Dr B noted that Mr A still felt sore around his tailbone after the fall and was still constipated. Dr B examined Mr A's coccyx and abdomen and found no masses or other abnormalities. Dr B referred Mr A for an X-ray, and noted: "[I]f constipation does not settle will need referral for change bowel habit." Dr B did not conduct a digital rectal examination (DRE)[3] or request any blood tests.

22. Dr B told HDC:

> "I did not consider that blood tests were necessary at that time. [Mr A] did not present with any symptoms that suggested I should order a blood test … I did not consider that [Mr A] presented with any symptoms that suggested that such an invasive examination [rectal examination] was warranted. [Mr A's] symptoms were consistent with an injury to his coccyx from his fall in February 2018."

23. On 20 March 2018, Mr A returned to Medical Centre 1 and spoke to a nurse about his X-ray result. The nurse told him that the X-ray showed no fracture, and recorded that Mr A

[1] A laxative.
[2] A laxative.
[3] An internal examination of the rectum.

asked why he was still sore if there was no fracture. The nurse advised that he might have a sprain, and that most likely the area was bruised. Mr A also asked why he was feeling nauseous all the time, and the nurse told him that constipation can bring on nausea. Mr A told the nurse that his bowels were fine. This information was recorded in the clinical notes.

24 March 2018 — consultation with Dr C

24. On 24 March 2018, Mr A consulted Dr C at Medical Centre 1, as Dr B was not available. Mr A's main concern was that he was passing more wind than usual, he sometimes had diarrhoea, and he felt discomfort in his abdomen. Dr C noted Mr A's earlier tailbone injury, and that "when [he] passed [a] motion [he] felt [his] heart racing". Mr A told Dr C that he had had a normal bowel motion that morning. Dr C advised Mr A that if his symptoms worsened he should return and be reviewed by his usual GP. Dr C did not perform a DRE.

25. Dr C told HDC that Mr A did not describe anal or rectal pain at any time during the consultation, and the main focus was that he was passing more wind than usual. She said:

> "Given the information [Mr A] gave me there were no red flags such as weight loss, unexplained change in bowel habit, weakness or fatigue, blood or mucous in stool … none of the clinical guidelines recommend a rectal examination for the symptoms of flatus."

26. Dr C also told HDC:

> "Given hindsight, it is unfortunate that I did not do a rectal examination at this time. However during my consultation with [Mr A] I did not believe there was sufficient reasoning to do this."

3 April 2018 — consultation with Dr D

27. On 3 April 2018, Mr A was seen by Dr D at Medical Centre 1, as Dr B was still unavailable. Dr D recorded in the clinical notes that Mr A complained of an ongoing change in his bowel habit, which had continued for five weeks, and that he had been passing more wind than usual and had diarrhoea. Dr D also noted that Mr A had no weight loss, but was feeling sick and had mild lower abdominal pain, and was taking codeine for his previous injury. Dr D examined Mr A's abdomen and documented that it was "soft, [with] no masses, no guarding, no organome[ga]ly".

28. Dr D ordered a semi-urgent abdominal X-ray, a stool test, and blood tests, including ferritin[4] and haemoglobin[5] levels. He also advised Mr A that he should return in three weeks' time if his symptoms did not resolve. Dr D did not perform a DRE.

29. Medical Centre 1 said that Mr A's test results were normal, so did not raise any red flags, and Dr D was reassured that the change of bowel habit had been going on for only five weeks, and that Mr A had not lost any weight.

[4] A protein in the blood that stores iron.
[5] A protein in red blood cells that transports oxygen and carbon dioxide.

30. Dr D said that he does not routinely perform a DRE when infection has not been excluded as the cause of diarrhoea. He stated:

> "We have to make judgement calls about performing invasive examinations. To summarise, the following are the clinical reasons for the judgement call on that day:
>
> - The absence of red flag symptoms or symptoms that would mean the MOM [Map of Medicine] 'colorectal cancer — suspected' pathway had not yet been entered;
> - Diarrhoea not yet present for 6 weeks;
> - Diarrhoea not yet confirmed as being non infectious;
> - Codeine use believed likely to be causing the constipation;
> - Coccygeal sprain diagnosis already diagnosed by external palpation of coccyx;
> - Still within the time frame where a coccygeal injury could be expected to be causing pain."

5 April 2018 consultation

31. Mr A had his final consultation with Dr B on 5 April 2018. Medical Centre 1 said that because the constipation was worsening, Dr B referred Mr A for consideration of a colonoscopy.[6] Dr B did not perform a DRE. He recorded in the clinical notes:

> "No change. Not examined again today. [Mr A] is very concerned by change in bowel habit. Refer SOPD[7]? For colonoscopy."

32. The referral was sent on 5 April 2018. In the referral form, Dr B copied the medical notes from all the consultations between 16 February 2018 and 5 April 2018, and indicated that the referral was semi-urgent. No other details were provided in the referral form. The referral was accepted on 11 April 2018 and given semi-urgent priority. The expected wait time was up to four months.

33. Dr B told HDC:

> "I have been practicing as a GP for [many] years and I have never received negative feedback regarding my referral letters either from hospital colleagues or those in private practice. Our system provides GPs with a template referral letter in which we can enter the necessary information into fields and then the full letter is produced. I also add that this system is designed to assist GPs in producing referral letters efficiently given the nature of the environment that we work in. However it is not simply a data dump and is a system that many GPs use to produce their referral letters."

Subsequent events

34. On 12 April 2018, Mr A transferred to Medical Centre 2 and was seen by Dr F. Dr F recorded: "Patient complained of pain in his anus for the past 5 weeks. Was very

[6] A non-surgical procedure used to examine the digestive tract.
[7] Surgical Out Patient Department.

constipated." Dr F noted Mr A's history of having fallen on his coccyx, and that Mr A had reported "pain in anal canal". Dr F prescribed pain relief and scheduled another visit for Mr A.

35. Mr A had his second consultation with Dr F on 17 April 2018. Dr F noted that Mr A had been suffering from severe rectal pain for the past six weeks. Mr A reported no blood in the stool and no weight loss, but he had extreme pain when passing a bowel motion. Dr F conducted a rectal examination and recorded:

> "[E]xtremely painful in rectum with stenosis[8] of anal canal. I attempted a proctoscopy[9] but it was so intensely painful that I was unable to see much [and] I could not identity any haemorrhoids.[10]"

36. Mr A's intense pain led Dr F to contact an ambulance to transfer Mr A to the public hospital. A CT scan performed on 19 April 2018 identified an advanced rectal malignancy.[11]

37. Mr A underwent treatment for his rectal cancer, but he passed away a few months later.

Further information

38. Mrs A told HDC that Mr A repeatedly went to Dr B from 2016 to April 2018, and that his "pain was increasing". Medical Centre 1 told HDC that Mrs A was not present with Mr A at any of his consultations at Medical Centre 1.

39. Medical Centre 1 stated:

> "The Centre has appropriate policies in place to ensure that a consistent and acceptable level of care is achieved for every patient. The GPs had access to the relevant Health Pathways[12] during [Mr A's] consultation with them."

40. Dr B told HDC: "I accept that alternative explanations for [Mr A's] coccygeal pain should have been considered and I apologise for this omission." Dr B stated:

> "[Mr A's] coccyx was examined on two occasions: 16 February 2018 and 19 March 2018. A DRE was not undertaken as there was no history of colon cancer that I was aware of. Nor was there any bleeding, weight loss, abdominal pain or and rectal pain reported by [Mr A] at any time.
>
> …
>
> [T]he contemporaneous notes made by myself and two of my colleagues do not record rectal pain or anal pain at any time … I have no reason to think that there were any difficulties with doctor–patient communication between myself and [Mr A]."

[8] Narrowing.
[9] Examination of the anal cavity, rectum, or sigmoid colon.
[10] Swollen and inflamed veins in the rectum and anus.
[11] Cancer of the rectum.
[12] A web-based information portal that supports primary care clinicians in planning patient care.

41. A shared services agency told HDC that direct access to the colonoscopy e-referral form was made available to GPs in the DHB catchment from 2017.

Dr E's report

42. Medical Centre 1, Dr B, Dr D, and Dr C engaged GP Dr E to provide comment about the care provided to Mr A. In summary, Dr E advised the following:

a) The coccydynia diagnosis was reasonable, and a timeframe of approximately six months is reasonable to wait before considering other diagnoses.

b) There is uncertainty around which HealthPathways were to be used during 2018. However, the Map of Medicine[13] (MOM) was available until mid-2018. Further, the guidelines themselves should not be the sole determination of what is reasonable.

c) Constipation and diarrhoea are not accurate predictors of colorectal cancer. Further, given that Mr A was suffering from constipation that may have been related to medication, Dr D's approach was reasonable.

d) Although a DRE may have picked up Mr A's cancer earlier, this is not certain, as detection is dependent on the position of the tumour. In addition, DREs are no longer the preferred method of detection, and have proven unreliable.

e) When consideration is also given to the 2009 guideline "Suspected Cancer in Primary Care", Mr A was not presenting with all the symptoms necessary for urgent referral for a colonoscopy.

f) There are shortcomings in how our healthcare system supports primary care in cancer diagnosis.

g) The referral letter is very minimalistic in nature, and the DHB would have been justified in sending it back for more detail. At the time, the practice of data dumping was rife among GP colleagues, but with electronic referrals and the standardised referral forms required in a main centre region, the practice is now unusual.

h) It is not clear that direct access to colonoscopy is available in the region. It is likely that the only option is for a GP to refer to a surgeon, who will prioritise a colonoscopy or Surgical Out Patient Department assessment.

Changes made since incident

43. Dr B told HDC that as a result of this incident he made changes to his practice, and has undertaken the following:

a) He completed the BMJ Learning[14] module on colorectal cancer.

[13] A clinical pathway tool used in the region from 2012.

b) The GPs at Medical Centre 1 discussed this case and the complaint at their regular peer group meetings.

c) He set up a new template for his clinical notes to facilitate better and more detailed record/note taking. He now errs on the side of providing more information.

44. Medical Centre 1 told HDC that as a result of this incident it identified areas for staff improvement, and undertook the following:

a) Mrs A's complaint was discussed at the management meeting on 4 February 2019.

b) It reviewed its processes, including:

i. Access to the online system where policy and procedures documents are kept;

ii. Ensuring that all clinical staff have access to HealthPathways; and

iii. Reviewing the Management Result and Clinical Correspondence policy to ensure that all its GPs are managing patients appropriately in the absence of the patient's registered GP.

Medical Centre 1's policy

45. Medical Centre 1's HealthPathways and Other Clinical Decision Support Tools policy (February 2016) states:

> "[Medical Centre 1] doctors and nurses use clinical decision support tools to assist with the care and management of our patients.
>
> HealthPathways
>
> Developed jointly by primary and secondary care clinicians, HealthPathways provided guidance particularly for general practice teams. The pathways are read by other registered health professionals to diagnose and manage patient suffering from a number of different conditions … As the pathways are suggested guidance only, clinicians using them must exercise their own clinical judgement and use pertinent clinical data when treating their patients."

Responses to provisional opinion

Mrs A

46. Mrs A was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. She emphasised her recollection that her husband did not fall on 10 February 2018, but rather that he fell around 16–17 December 2017.

Dr B

47. Dr B was provided with an opportunity to comment on the provisional opinion.

[14] BMJ Learning offers continuing medical education for doctors and other healthcare professionals. It features hundreds of accredited, peer-reviewed learning modules in text, video, and audio formats.

48. Dr B referred to Dr E's advice that it was appropriate to wait for six months to see whether the coccygeal injury resolved, and that therefore there was no basis to perform a DRE earlier.

49. Dr B emphasised that Mr A did not inform him of any rectal pain. Dr B said that he did turn his mind to alternative diagnoses, as evidenced by his consideration of a colonoscopy referral on 19 March 2018, and that "there is no actual evidence to suggest that [he] failed to communicate properly with [Mr A] to elicit information from him during their consultations." Dr B also stated:

> "[I have] acknowledged that alternative diagnoses should have been considered in more detail. However, this is not an admission, but a concession with the benefit of hindsight … There was no reason to consider alternative diagnoses any earlier [than 19 March 2018] and … there is no basis for finding [me] in breach for a lack of critical thinking."

Dr D and Dr C

50. Both Dr D and Dr C were provided with an opportunity to comment on the provisional opinion. They said: "[We] are willing to follow the HDC's suggestions for improving [our] practice in this case …"

Medical Centre 1

51. Medical Centre 1 was provided with an opportunity to comment on the provisional opinion, and had no further comments to make.

Relevant standards

52. At the time of events, the region's GPs were expected to refer to MOM, which was the relevant pathway until the transition to HealthPathways in 2018.

53. The MOM (April 2018) states:

> "Colorectal cancer — suspected
>
> …
>
> In New Zealand: … almost three quarters of cases occur in people aged 65 years and older, and more than a third of cases in people age 70 years and older
>
> …
>
> 4. Colorectal cancer — clinical presentation
>
> Most patients with colorectal cancer will present with:
>
> - Rectal bleeding (with or separate from the faeces)

- Changes in bowel habit, such as:
  - Increased frequency of defaecation
  - Looser stools
- Non-specified symptoms eg tiredness due to undetected blood loss
- Abdominal pain

…

6. Examination …

- Digital rectal examination (DRE), if the patient:
  - Is age 40 years or older
  - Has persistent symptoms
  - Has symptoms suspicious of colorectal cancer

…

11. Moderate risk features

A referral to surgical outpatients should be made if:

- Altered bowel habit (looser and/or more frequent) > six weeks duration, aged > 50 years
- Altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding aged 4–50 years …"

54. The Ministry of Health's Suspected Cancer in Primary Care (2009) states: "For a person presenting with the same symptoms, or symptoms complex, three or more times, a practitioner needs to exclude cancer, and referral to a specialist must be considered."

Opinion: Introduction

55. From 2010, Mr A had a history of constipation. From 16 February 2018, he had six consultations at Medical Centre 1 about pain in his coccygeal area and a change of bowel habit. This report concerns the care provided by Medical Centre 1 during Mr A's four consultations with Dr B and one consultation each with Dr C and Dr D.

Opinion: Dr B — breach

Introduction

56. Mr A first presented to Dr B on 16 February 2018 following a fall at home. Dr B examined Mr A's sore tailbone and also discussed Mr A's constipation. Mr A continued to experience constipation, and also had loose bowel motions, and consulted Dr B again on 8 March 2018. Dr B noted that Mr A's coccyx was still sore.

57. On 19 March 2018, Mr A again presented to Dr B with continuing constipation and a sore tailbone. Dr B examined Mr A's coccyx and abdomen and found no abnormalities. Dr B referred Mr A for an X-ray and recorded in the clinical notes that if his constipation did not settle, he would need to be referred for a colonoscopy, owing to his change in bowel habit.

58. Mr A had his final consultation with Dr B on 5 April 2018, and was referred to the surgical outpatients unit for consideration of a colonoscopy. Mr A's condition deteriorated, and on 12 April 2018 he sought a second opinion from a new GP, Dr F, who noted Mr A's pain in the anal canal.

Differential diagnosis

59. Mr A's pain in the coccygeal area was noted at all his consultations at Medical Centre 1. When eventually Mr A changed to Medical Centre 2, Dr F noted that specifically Mr A had pain in his anus, which he had been experiencing for the past five weeks.

60. My expert advisor, Dr Jim Vause, considers that if Mr A specifically complained of rectal pain to the Medical Centre 1 doctors, their failure to consider an alternative diagnosis was a severe departure from accepted care.

61. Mrs A told HDC that her husband repeatedly complained to her about "pain in his bottom", and that this was communicated to Dr B. However, Mrs A was not present at any of her husband's consultations at Medical Centre 1.

62. In contrast, Dr B advised that Mr A did not complain specifically about pain in his anal or rectal region, but said that the pain was mainly around his tailbone area. Similarly, both Dr C and Dr D said that Mr A did not inform them that he had pain in his rectal region, and this information was not recorded in his clinical notes by any of the GPs at Medical Centre 1. Dr B understood that the pain around Mr A's coccygeal area was because of his fall, and no other diagnosis was noted. In response to my provisional opinion, Dr B said that he did turn his mind to alternative diagnoses, as he considered a colonoscopy referral on 19 March 2018, and there was no basis to consider alternative diagnoses any earlier.

63. Given the evidence available, I consider it possible that Mr A may not have specifically mentioned anal or rectal pain to Dr B or to the other GPs at Medical Centre 1. However, it is clear that Mr A did describe pain in his general perineal region.

64. Dr Vause advised:

> "[Dr B's] comments … that neither rectal nor anal pain were documented by any of the doctors at [Medical Centre 1] indicates an excessive reliance on a patient's ability to differentiate the locality of pain arising from the perineal region in any of three different locations that are less than 3 cm from each other … the labels coccyx, anus and rectum are terms doctors use but patients usually do not have the same discriminatory anatomical knowledge … Thus, a doctor should not totally rely upon a patient's verbal description of pain locality and, as [Dr B] stated, an alternative diagnosis should have been entertained."

65. I have noted Dr E's opinion that a coccydynia diagnosis was reasonable, and that a timeframe of approximately six months is reasonable before considering other diagnoses.

66. However, in response, Dr Vause noted that a diagnosis of coccydynia was not documented in the clinical records, but rather one of an injury to Mr A's coccyx. Dr Vause also advised:

> "[S]ix months may be an acceptable duration to wait for coccyx pain symptoms to resolve assuming the case was injury but it does not absolve a doctor of a duty to consider other diagnosis to account for [Mr A's] problem when he also presented with additional symptoms in the same body region, particularly the four times in 18 days in March to April 2018."

67. Dr Vause stated:

> "[W]hen this is added to the presentations to [Dr B] with bowel symptoms … the need for alternative diagnosis is even greater and a pathology in the regions of the body immediately adjacent to the coccyx, namely the anus and rectum, should have been considered."

68. Mr A repeatedly presented to Dr B with pain in his tailbone area and changing bowel habits. Having considered Dr Vause's advice and Dr E's opinion, I consider that Dr B should have enquired further about the exact location of Mr A's pain. In my opinion, a lack of critical thinking by Dr B precluded consideration of an alternative diagnosis for Mr A's symptoms.

69. Dr B accepted that alternative explanations for Mr A's coccygeal pain should have been considered, and apologised for the omission.

Failure to perform DRE

70. Dr B did not perform a DRE at any of his consultations with Mr A, including at the final consultation on 5 April 2018. Dr B said that a DRE was not undertaken as Mr A had no family history of colon cancer, and he had no rectal bleeding, weight loss, abdominal pain, or rectal pain. In response to my provisional opinion, Dr B referred to Dr E's advice and said that it was appropriate to wait to see whether the coccygeal injury resolved, so there was no basis to perform a DRE earlier. Following the consultation on 5 April 2018, Dr B referred Mr A to the surgical outpatients unit for consideration of a colonoscopy.

71. The MOM states that people aged 70 years and over have a higher chance of colorectal cancer, and that clinical presentation indicative of colorectal cancer may include a change of bowel habit, abdominal pain, and rectal bleeding. The MOM also states that a DRE should be performed if the patient is aged 40 years or over, has persistent symptoms, and/or has symptoms suspicious of colorectal cancer. The MOM also states that a DRE should be performed before a referral to the surgical outpatients unit.

72. Dr Vause said that the MOM was available to GPs until July 2018, and that between March and April 2018, the MOM was in use and available to GPs.

73. Dr E stated that in the region during 2018 there was uncertainty around which health pathways were to be used, but he accepted that the MOM was available until mid-2018. Dr E also stated that DREs are no longer the preferred method of detection for colorectal cancer and have proved to be unreliable.

74. Dr Vause advised that the MOM was not followed. He stated:

> "Certainly on the 5 April [Dr B's] care for [Mr A] was not of an acceptable standard … [Dr B] should have excluded other diagnosis and performing a rectal examination would be the first clinical examination to undertake."

75. I accept Dr Vause's advice. I acknowledge that at Mr A's consultations with Dr B prior to 5 April 2018, Mr A was exhibiting symptoms of coccygeal pain, and a DRE may have not been indicated at that time. However, Mr A's symptoms of pain in the tailbone area persisted, and a change in bowel habit was noted. At the consultation on 5 April 2018, Dr B referred Mr A for a colonoscopy, and at this time a DRE should have been performed, as per the MOM.

Quality of referral on 5 April 2018

76. As discussed above, following the final consultation on 5 April 2018, Dr B referred Mr A to the public hospital. In the referral letter, Dr B copied and pasted the clinical notes from the consultations between 16 February 2018 and 5 April 2018. Dr B told HDC that at the time, this system was used by many GPs to produce their referral letters, and he had been using the method for many years.

77. Dr E said: "[T]he referral letter is very minimalist in nature and I would consider that the DHB would be justified in sending it back for more detail."

78. Dr Vause advised that Dr B's referral letter was "inadequate". Dr Vause stated:

> "[Dr B] needs to improve the quality of his referrals and not simply use a data dump from the [clinical notes] to justify his transfer of care to the General Surgeons at the DHB. He should engage with the surgeons at the hospital to whom he refers patients to identify the characteristics of a referral that enable the surgeons to accurately assess the patient urgency of care."

79. I am critical that Dr B simply copied and pasted the clinical notes into his referral letter without any further explanation of Mr A's presenting concerns.

Conclusion

80. In summary, I consider that Dr B failed to provide appropriate care to Mr A in the following ways:

a) There was a lack of critical thinking about alternative diagnoses, given Mr A's pain around his tailbone area and changing bowel habit;

b) The location of Mr A's pain was not assessed adequately;

c) A DRE was not performed at the consultation on 5 April 2018; and

d) The referral letter on 5 April 2018 was not adequate.

81. These deficiencies in the care provided contributed to a delay in Mr A receiving appropriate investigations. In my opinion, Dr B did not provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: Dr C — adverse comment

82. Mr A consulted Dr C on 24 March 2018. Mr A had seen Dr B five days previously (on 19 March 2018), and at that consultation Dr B noted that Mr A might require a referral for a colonoscopy. Dr C said that the main purpose of Mr A's consultation was that he was passing more wind. She did not perform a DRE, and told HDC that given the information Mr A gave her, there were no red flag symptoms for a DRE.

83. Dr Vause advised that he is "inclined to find her care for [Mr A] reasonable although her failure to verify [Dr B's] coccyx examination findings from five days prior was a mistake, as was her decision to not perform a rectal examination".

84. I accept Dr Vause's advice that a rectal examination should have been performed, and that Dr C could have given more consideration to Dr B's note that Mr A might need a referral for a colonoscopy. Accordingly, I am critical of the care provided by Dr C.

Opinion: Dr D — adverse comment

85. Mr A consulted Dr D on 3 April 2018. Dr D noted that Mr A had experienced ongoing changes to his bowel habit for five weeks. Dr D arranged a semi-urgent X-ray, a stool test, and blood tests, and advised Mr A to return in three weeks' time if his symptoms did not resolve. Dr D said that he did not conduct a DRE because Mr A's diarrhoea had yet to be

confirmed as non-infectious, there was an absence of other symptoms of colorectal cancer such as weight loss or rectal bleeding, and the diarrhoea had not been present for six weeks.

86. Dr E stated that constipation and diarrhoea are not accurate predictors of colorectal cancer and, in his opinion, given that Mr A was suffering from constipation, Dr D's approach was reasonable.

87. Dr Vause advised:

> "[I find Dr D] asking [Mr A] to wait three weeks for a review following his x-ray and blood tests for a possible sub acute bowel obstruction and bulk laxative therapy, along with his reasoning for not performing a rectal examination, to be unreasonable. This is a mild departure from an acceptable standard of care."

88. Dr Vause also stated:

> "[Dr D's] statement … of not performing a rectal examination on a patient with three weeks diarrhoea because it might be infectious, is not consistent with a conviction that the problem was constipation. Additionally, it is a rationale I have never encountered in 43 years of practice and for which I cannot find any supporting research.
>
> Furthermore, while [Dr D] clearly knew of [Mr A's] tailbone injury and his four prior presentations to [the medical centre] when he saw [Mr A] on 3 April 2018 … he does not appear to have considered that the tailbone pain and bowel changes could be related."

89. I note that Mr A did not show other signs of colorectal cancer such as rectal bleeding or weight loss. However, I accept Dr Vause's advice, and consider that a wait of three weeks for Mr A's next review following this consultation was too long. I also consider that Dr D's decision not to perform a DRE was unreasonable. In my opinion, Dr D should have given more consideration to the possibility that Mr A's tailbone pain could be related to his change in bowel habit, which had been ongoing for more than five weeks. Accordingly, I am critical of the care provided to Mr A by Dr D.

Opinion: Medical Centre 1 — no breach

90. As a healthcare provider, Medical Centre 1 is responsible for providing services in accordance with the Code.

91. As detailed above, I have found that Dr B breached the Code. Dr Vause advised:

> "I do not find any evidence that there was a systematic failure at [Medical Centre 1]. The failure was that no doctor, until [Dr F], adequately examined [Mr A] to account for his persistence of coccyx region pain and his alteration in bowel motion."

92. Dr Vause stated that the policies at Medical Centre 1 during Mr A's presentation were appropriate, and it was also reassuring that the doctors at Medical Centre 1 had electronic access to the MOM.

93. For these reasons, I consider that the errors that occurred did not indicate broader systems or organisational issues at Medical Centre 1. Therefore, I consider that Medical Centre 1 did not breach the Code.

Other comment

94. Both Dr Vause and Dr E commented that in the area in 2017 it was not clear that a direct colonoscopy route was available to GPs. I note that the health services agency told HDC that an e-referral form for direct access to colonoscopy was made available to GPs in the DHB catchment from March 2017. However, I also note that Mr A would not have fulfilled the criteria for direct access to a colonoscopy.

Recommendations

95. I recommend that Dr B:

a) Provide a written apology to Mrs A for the breaches of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mrs A, within 11 weeks of the date of this report.

b) Undertake further training on communication and colorectal cancers, in particular the use of HealthPathways, and provide HDC with evidence of having completed the training within six months of the date of this report.

96. I recommend that Dr C:

a) Provide a written apology to Mrs A for the adverse comment made in this report. The apology is to be sent to HDC, for forwarding to Mrs A, within 11 weeks of the date of this report.

b) Undertake further training on colorectal cancers, in particular the use of HealthPathways, and provide HDC with evidence of having completed the training within six months of the date of this report.

97. I recommend that Dr D :

a) Provide a written apology to Mrs A for the adverse comment made in this report. The apology is to be sent to HDC, for forwarding to Mrs A, within 11 weeks of the date of this report.

b) Undertake further training on colorectal cancer, in particular the use of HealthPathways, and provide HDC with evidence of having completed the training within six months of the date of this report.

98. I recommend that Medical Centre 1 report back to HDC regarding the review of its process (as stated at paragraph 44 of this report) within six months of the date of this report.

Follow-up actions

99. 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 the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

100. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to DHBs in the region and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to Commissioner

The following expert advice was obtained from Dr Jim Vause:

"Re complaint: [Dr B] at [Medical Centre 1]

Your reference: C18HDC02354

In reply to your request to provide advice to the Commissioner on the care provided for [Mr A] by [Dr B] at the [Medical Centre 1] between 2016 and 2018:

I have read and agree to follow the H&DC Appendix H: Guidelines for Independent Advisers.

March 2019

I am a vocational registered general practitioner, having graduated MBChB from Otago University in 1976. I have practised as a GP since 1979, initially in Central Otago till 1986 and thereafter in Blenheim where I am still in practice. I gained Membership of the Royal New Zealand College of General Practitioners in 1989, Fellowship in 1993 and received a Distinguished Fellowship in 2005. I am also an Honorary Fellow of the Royal Australian College of General Practitioners. In 2001 I gained a Diploma of General Practice from Otago University. I have worked extensively in the realm of evidence based medicine in the production and evaluation of Clinical Guidelines, including as team leader for the New Zealand Guidelines Group, Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparities.

My report is based on the evidence provided by the Commissioner, namely

1. Summary letter of complaint from [an advocate]
2. Letter of complaint from [Mrs A]
3. [Medical Centre 1] response dated 25 Feb 2018 including a printed copy of the computer medical records from 4 March 2016 until 23 May 2018.
4. Printed copy of computer medical records from [Medical Centre 2] from 12-04-18 until 13-11-18
5. Printed copies of investigation results requested from [Medical Centre 1]
6. Printed copy of the referral from [Dr B] to [the DHB's] general surgery department dated 11-04-18

In reply to your question on the appropriateness of the care provided to [Mr A] by the [Medical Centre 1] over the years 2016 to 2018:

In determining the standard of care/accepted practice, the standards I have used for the management of a patient presenting in this manner are the Health Pathways provided by each DHB in New Zealand. I cannot access the [region's] DHB pathways, only being able to access the Nelson Marlborough Pathways which I have used for

standards of care in this case. The Health Pathways are based on the National Referral Guidelines. Unfortunately the only such National Guidelines I can access are the current ones dated 2019, however they appear to be consistent with previous National Referral Guidelines that would have been applicable in 2018. The referral criteria contained in the Health Pathways and the National Referral Guidelines are based on the New Zealand Guidelines Group, Ministry of Health, 2009 — Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparities.

There are no specific guidelines or pathways covering coccyx injury or fracture. Therefore the standard I have used is based on my personal knowledge and experience of 43 years of practice as a doctor which has included many cases of tailbone injury and a number of cases of rectal cancer. I note that the websites WebMD, Mayo Clinic and Wikipedia refer to the fact that a rectal examination may be necessary in patients presenting with a tailbone injury or pain.[i] [ii]

In considering this case the significant discrepancy between [Mrs A's] account and the medical records requires two separate scenario assessments consistent with your request.

Scenario a)

as per the deceased's wife's ([Mrs A's]) account in her complaint letter.

The document, dated August 25 2016, states that [Mr A] had a sore rectum for 2 years of such degree that he

'wasn't able to drive much to[o] sore'

and that he never had constipation. She also states, concerning her husband's 19 March 2018 consultation with [Dr B] that

'No examination ever for sore rectum'.

She highlights [Mr A's] repeated consultation in March and April 2018 concerning constipation and asks

'Surely alarm bells would have told them something was wrong.'

Assessing the actions of the [Medical Centre 1] doctors, under this scenario, clearly their care for [Mr A] was of an unacceptable standard for failing, given a two year history of rectal pain, to conduct a rectal examination or consider an alternative diagnosis in March and April 2018 to account for his repetitive presentation with both constipation and rectal pain. This departure from accepted care was severe. However the problems around dates of presentation of [Mr A's] symptoms greatly reduces any confidence in this assessment.

Scenario b)

as per the clinical records and the letter from the [Medical Centre 1 Business Manager]. The records appear to be a contemporaneous record of events.

In these the 25 August 2016 consultation records [Mr A] as presenting for a driver's licence medical and a repeat of his cardiac medications plus laxsol (for constipation) which I note he had been prescribed previously in about May. No mention is made of bowel problems or a sore rectum. I also note on the first page of the letter penned by the business manager at [Medical Centre 1] that

'[Mr A] experienced constipation issues from 2010 with occasional requests for laxative from that time onwards'.

This being contrary to [Mrs A's] letter.

Timeline

Visit one: 16 February 2018 [Dr B] [Medical Centre 1]

The first medical record possibly relating to [Mr A's] rectal cancer is on 16-02-18 when his fall onto his tailbone is presented. I note that [Mrs A] states the event occurred on December 16–17 of 2017 but that the date of injury on the ACC form submitted on 19 March 2018 is 10-02-18. The clinical notes submitted to me do not include the date of injury and the ACC ARC18 is not presented. The clinical notes document that [Dr B] did examine [Mr A's] coccyx with the entry

'O/E (on examination) tender coccyx'.

There are no other recorded observations such as whether or not there was bruising or other signs of trauma.

Visit two and three: 8 March and 19 March, [Dr B] [Medical Centre 1]

Subsequent consultations on 8-3-18 and 19-03-18 with [Dr B] has [Mr A] presenting with a sore coccyx and constipation. [Dr B] examines his abdomen on both occasions and his coccyx on the 19th. In addition he requests an X-ray of [Mr A's] coccyx but the presented records have no documentation of the clinical content of this request form. I note that [Dr B] indicated on the 19th that '*if constipation doesn't settle will need referral for change bowel habit'.*

Visit four: 20 March ?nurse, [Medical Centre 1]

On the 20th March there is an entry which appears to be a different clinician judging from its content and structure, most likely a nurse. This clinician records a new symptom, namely nausea.

Visit five: 24 March [Dr C], [Medical Centre 1]

On 24 March is the entry by [Dr C] which records [Mr A] experiencing an increase in flatus, a small amount of diarrhoea, incontinence of faeces, abdominal discomfort sometimes and she notes:

'hurt tailbone recently but not taking analgesia for this'.

She did not examine his coccyx, only recording examination of his abdomen.

Visit six: 3 April [Dr D], [Medical Centre 1]

On 3 April [Mr A] sees [Dr D] who records significant new anal symptoms, a change in bowel motion frequency and that [Mr A]

'feels sick'.

He decides to exclude a sub-acute small bowel obstruction and initiates a number of investigations but fails to record any examination of [Mr A's] coccyx or anal/rectal region. This was [Mr A's] fifth presentation with coccyx pain and bowel motion problems. These investigations are all normal although [Mr A] did not provide the faeces sample for a culture, a test that I would not have expected to alter the course of [Mr A's] problems.

Visit seven: 5 April [Dr B], [Medical Centre 1]

On 5 April, [Dr B] sees [Mr A] and decided to initiate a referral for colonoscopy based upon [Mr A's] symptomatology of change in bowel habit. It appears he does not consider the coccyx pain to be significant for he does not mention it in his inadequate referral letter.

Visit eight: 12 April [Dr F], [Medical Centre 2]

On 12 April [Mr A] sees [Dr F] at the [Medical Centre 2] who records his symptoms as

'pain in the anus for the past five weeks'

along with noting that he

'also fell on his bottom'.

He conducts, or attempts to conduct, a rectal examination but severe pain prevents this. He gives [Mr A] some suppositories that contain a local anaesthetic and sees him a week later for further rectal examination at which time he actions an urgent referral to the surgeons at the DHB based on this rectal examination findings, [Mr A] being admitted to hospital that same day.

Assessment:

Looking at the overall care from [Medical Centre 1] based on the clinical records, the fact that [Mr A] had six presentations with bowel habit symptoms and coccyx pain, without a rectal examination being performed, is a significant failure of care.

Looking at the individual doctor's care:

[Dr B]

His care for [Mr A] appears acceptable in the early consultations based on [Mr A's] presentation with a tailbone injury and constipation, a symptom he has had in the past. He does consider a referral to investigation of a change in bowel habit on 19 March although this is puzzling, for at this stage [Mr A's] history was a long one of constipation according to the notes and constipation is NOT a criteria for referral for colonoscopy. In addition, despite considering a possible referral, he did not undertake the blood tests that are necessary for such a referral (as per the pathways) and did not undertake or even consider a rectal examination, despite the health pathways stating, for all referrals of a patient with colorectal symptoms

'A rectal examination is mandatory in all patients'.

His care re [Mr A's] coccyx injury in isolation might be considered acceptable had it only been two or three consultations on the matter, however [Mr A] had a total of six consultations at [Medical Centre 1], four of them with [Dr B], without any other possible cause for his coccyx pain being considered. By the time [Dr B] had decided to refer [Mr A], his decision to refer [Mr A] without any further examination was based on [Mr A's] *'… concerned about change in bowel habit'* and not his coccyx pain.

[Dr B's] record of [Mr A's] symptoms at this time is significantly different from those obtained seven days later by [Dr F] of [Medical Centre 2] records, namely that [Mr A] had

'anal pain for the past 5 weeks'.

It is difficult to accept that [Mr A's] symptomatology changed significantly between 5 and 12 April which points to a significant failing on [Dr B's] part to adequately explore [Mr A's] symptoms. This difference in symptoms recording suggests difficulties with doctor patient communication on the 5 April however [Dr B's] brief records contain no hint of such.

Certainly on the 5 April [Dr B's] care for [Mr A] was not of an acceptable standard for he failed to exclude other diagnosis to account for [Mr A's] five previous presentations with coccyx pain and/or altered bowel habits. While [Mr A's] fall onto his bottom in December would lead to an obvious coccyx injury diagnosis, with repeated presentations combined with the bowel habit changes, [Dr B] should have excluded other diagnosis and performing a rectal examination would be the first clinical examination to undertake. The fact that even the referral on 5 April was based on [Mr A's] concern about his change in bowel habit and NOT because of the misdiagnosed coccyx pain takes his care for [Mr A] further from an acceptable standard.

This, in my opinion is at least a moderate departure from an acceptable standard of care.

[Dr C] 24 March

[Dr C] only saw [Mr A] once on 24 March. He presents to her some changes in his bowel symptoms away from constipation and persistence but possible reduction of his coccyx pain. Her failure to perform a rectal examination was a significant oversight on her part, more so given [Dr B's] concern about the need for a possible referral five days prior for colorectal symptoms, a referral that would have triggered a rectal examination as per the Health Pathways.

This, in my opinion is at least a mild departure from an acceptable standard of care.

[Dr D] 3 April

Like [Dr C], this was his first consultation with [Mr A] and he identifies clearly

'Change in bowel habit five weeks'.

His tentative diagnosis was incorrect but nevertheless he acts appropriately except for failing to perform a rectal examination as per the pathways and his decision to delay a referral until [Mr A] had 8 weeks of change in bowel habits, rather than the 6 weeks in the national referral criteria was an error in understanding the pathways.

This in my opinion, is not an acceptable standard of care, being at least a minor departure.

How would it be viewed by your peers?

I obtained three separate opinions from colleagues whose opinion I trust. All three agreed that [Dr B's] departure was at least moderate. On the performance of Drs [Dr C] and [Dr D], two peers felt the departure in care by both doctors was moderate, given that both of these doctors had access to the records of [Mr A's] previous consultations. My third colleague did not give an opinion on the degree of departure of these two doctors.

Recommendation for improvement that may help to prevent a similar occurrence in the future?

The doctors at [Medical Centre 1] need to conduct a root cause analysis of this case with a review group of vocationally qualified general practitioners external to the practice, utilising the standards of care in the Health Pathways.

[Dr B] needs to improve the quality of his referrals and not simply use a data dump from the PMS system to justify his transfer of care to the General Surgeons at the DHB. He should engage with the surgeons at the hospital to whom he refers patients to identify the characteristics of a referral that enable the surgeons to accurately assess the patient urgency of care. He should also reflect on why he did not elicit from [Mr A] the characteristics of his pain that were presented to [Dr F] one week later.

Throughout this assessment I have presumed all the doctors at [Medical Centre 1] have easy computer access to the [region's] Health Pathways. Should this not be the case, then the issue must be addressed by the practice.

Any other comments you may wish to make on the care provided to [Mr A]?

Given the significant discrepancy between the two accounts as to when [Mr A] initially presented to [Dr B] with rectal or coccyx pain and on the matter of his duration of constipation, it would be useful to verify the contiguous nature of the [Medical Centre 1] notes as the notes, as presented to me, are printed output from the PMS system and do not contain any data from the inbuilt audit trail of entries and modifications to the PMS record. If this audit trail proves the notes of this time frame are as they were entered on the dates of consultation and unaltered, then it might help reassure [Mrs A] on the accuracy of the events as recorded in the [Medical Centre 1] computer.

The lack of identification of the attending clinician in the [Medical Centre 1] notes is a significant oversight and does not meet the accepted standard for a medical practice's PMS system, namely indicator 21.1 of the RNZCGP Foundation standards 2016[iii]. The practice should institute changes to its PMS system to correct this although it may simply be a problem in the printing of the computer records.

Concerning the process of assessment of [Mr A's] care, the printed medical records from [Medical Centre 1] as initially presented to me were incomplete. While much of this deficit was addressed, it is possible that some components of the records which may have a bearing on my findings remain unsighted, for example the ACC form. Such a discrepancy between printed and digital records can pose a problem to this type of inquiry, more so with the increasing complexity of general practice PMS systems, the distributed databases of health care records and the use of portals for patient access to their medical records.

I trust this opinion aids the Commissioner in his findings on the care for [Mr A].

Naku na

Dr GHJ Vause
MBChB FRNZCGP (Dist) DipGP"

The following further expert advice was obtained from Dr Vause:

"…

Thank you for the additional information relating to this case, namely

- Letter from [lawyer] dated 6 June 2019 with the x-ray result and [Mr A's] ACC form;
- Relevant Map of Medicine pathway;
- Relevant [regional] Community Health pathways detail;
- 2012 version of National Referral Crit

In reply to your request to

1. review the attached documents;
2. comment whether this further information causes you to change your advice in any way;
3. provide any further comments you wish to make.

The documents are useful but do not change my advice.

Neither the ACC45 nor the Xray request form provide any significant new information.

The two clinical pathways are valuable in confirming that the basic standard of care of a patient whom a GP in the [region] is considering referring to specialist care because of an alteration or change in bowel habit is the same as the Nelson Marlborough Health Pathways. I note that the transition from Map of Medicine to the Health Pathways began on July 2018.

While there are significant differences between the two pathway tools, both in content and structure, the key feature is that prior to referral for 'altered bowel habit' in the [region's] Health Pathways and 'changes in bowel habit' in the [region's] Map of Medicine, a rectal examination is required.

The Map of Medicine has three qualifiers, namely a rectal examination is required

if the patient

- is age 40 years or older
- has persistent symptoms
- has symptoms suspicious of colorectal cancer

The 2012 National Referral Criteria confirm that the criteria have not changed to any significant extent over time.

Thus these documents do not alter my conclusions.

In reply to the questions raised by [the lawyer]:

Reliance on [Mrs A's] recall

Because of the significant differences between [Mrs A's] account and those of the practice and doctors, as per the request made of me by the Commissioner, I presented my assessment based on each account separately. The conclusion based on [Mrs A's] account was that

'This departure from accepted care was severe'

as presented at the end of scenario a) on page three of my report to the Commissioner.

My conclusions based on the practice and doctors' accounts were provided in scenario b. This part of my report was more comprehensive, reflecting the greater content and quality of the information provided by [Medical Centre 1] and the doctors, compared with [Mrs A's] account.

Whether PMS included in scope of investigation

[The lawyer's] questioning as to whether the practice's PMS system was in the scope of my advice is answered by the central role of good medical records in the provision of continuity of medical care, as well demonstrated in [Mr A's] case where he was seen by three different doctors prior to a correct diagnosis of his anal pain. The manner in which this contemporaneous information is recorded, stored in and then presented to the clinicians by the computer system can significantly influence the quality of care. Thus in advising the Commissioner on the care provided, the PMS is an important consideration. While I cannot make a real time evaluation of how either the practice implemented its PMS or how the doctors used it, the printed information presented to me does have some features which point to possible problems in the PMS.

To further highlight the importance of the PMS system in the provision of quality general practice care, there are a number of indicators in Aiming for Excellence, the standards used by the RNZCGP Cornerstone Practice Accreditation program that have been introduced as a result of HDC findings, the patient test results (Indicator 24) being an exemplar of this, for to operate effectively, tracking and auditing of patient test results requires the correct implementation of a good quality PMS.

[The lawyer's] assumption that I lack familiarity with the Medtech 32 PMS system used by [Medical Centre 1] is counternanced by the fact that I first installed this PMS system in my four doctor practice in 1999 and for 13 years I not only used the system clinically as a GP, but I was also responsible for its implementation, maintenance and evolution in the practice until I changed the practice to another PMS system in 2012. Prior to this I was a member of the Medtech Clinical Advisory Committee in Auckland for three years until 2010. I left this when I was appointed to the Patient's First Panel evaluating the PMS systems then in use in New Zealand general practices. Medtech 32 was included in this review. Although my practice changed PMS as above, I continued to use Medtech 32 when working at the Marlborough After Hour GP service and I note that the PMS has changed very little between 2009 and now, consistent with the cessation of its development following Medtech Global's decision to concentrate on their new product Medtech Evolution in about 2010.

In addition, the great majority of printed medical records I have seen in my many HDC inquiries have been from Medtech 32 and I am very aware from the 50+ Cornerstone assessments of General practice I have performed around our country, of the differences in implementation of PMS systems and how this can affect the quality of care.

On the matter that [the lawyer] raises concerning the Cornerstone standard 22.1 that states:

'Patient records contain sufficient information to identify the patient and document: the reason(s) for a visit, relevant examination and assessment, management, progress and outcome'

It is important to note that 22.1 is a criterion in Aiming for Excellence. It is not a Cornerstone standard for Cornerstone is the accreditation process.

I note that [Medical Centre 1] has current Cornerstone Accreditation. General practitioners in a practice undergoing Cornerstone have to perform, as part of Aiming for Excellence Indicator 22.1, an audit of 20 of their clinical notes against a number of measures, among them being that every consultation record has an entry that is dated and

'the person making the entry is identifiable'.

This is contained in the Interpretation Guide for Aiming for Excellence Standard that is provided to all practices undertaking Cornerstone. I have in my possession and can forward the 2012–16 version of this. The RNZCGP will have all the versions available although to the best of my recall, in earlier versions of Aiming for Excellence, the guidance notes were contained within the main book of indicators.

I trust this answers both your requests and the concerns of [the lawyer].

Yours sincerely

Dr GHJ Vause MBChB FRNZCGP (Dist) Dip GP"

The following further expert advice was obtained from Dr Vause:

"…

Re Complaint: [Medical Centre 1]/[Mr A]

Ref: 18HDC02354

Thank you for the request to provide further expert advice on the matter of the care provided by the [Medical Centre 1] to [Mr A] in 2018.

I have read the Guidelines for Independent Advisors March 2019.

I am a vocational registered general practitioner, having graduated MBChB from Otago University in 1976. I have practised as a GP since 1979, initially until 1986 in Central Otago, then in Blenheim until 2019 and I am now in practice in Stoke. I gained Membership of the Royal New Zealand College of General Practitioners in 1989, Fellowship in 1993 and received a Distinguished Fellowship in 2005. I am also an Honorary Fellow of the Royal Australian College of General Practitioners. In 2001 I

gained a Diploma of General Practice from Otago University. I have worked extensively in the realm of evidence based medicine in the production and evaluation of Clinical Guidelines, including as team leader for the New Zealand Guidelines Group, Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparities.

I have received and appraised the following documents:

1. Letter of complaint from Advocacy Service dated […]
2. [Medical Centre 1's] response dated 2 February 2019 including clinical notes and its attachments
3. [Medical Centre 2's] medical note
4. Lab test result and referral letter to DHB from [Medical Centre 1]
5. Letter from [the lawyer] dated 6 June 2019 with the x-ray result and [Mr A's] ACC form
6. Relevant Map of Medicine pathway
7. Relevant [regional] Community Health pathways detail
8. 2012 version of National Referral Criteria
9. File note of the phone discussion with [Dr F] (the new GP)
10. [Medical Centre 1's] response dated 22 August 2019 with statements from [Dr C] and [Dr D]
11. [Dr B's] response dated 22 August 2019
12. Letter from [the lawyer] dated 22 August 2019;
13. [Dr E's] report
14. Further clinical notes from [Medical Centre 1]
15. [Medical Centre 1's] Patient Record requirements
16. [Medical Centre 1's] policies
17. Relevant screen shots from [Medical Centre 1]
18. Aiming for Excellence: The RNZCGP Standard for New Zealand General Practice
19. [The region's] DHB Map of Medicine — Colorectal cancer
20. Health Pathways Colorectal symptoms
21. Article regarding Transition from Map of Medicine to Health Pathways

Thank you for the new documentation, namely items 6–21.

I have amended my conclusions in light of the information provided on the Map of Medicine, the report by [Dr E] and the statements from [Dr B], [Dr C] and [Dr D].

In reply to your request to comment on

1. The appropriateness of [Medical Centre 1's] policies and its accessibility for doctors to the Health Pathways;

The updated clinical records provided by [Medical Centre 1] address my concerns on the matter of the identification of clinicians and are consistent with the postulate in my report that the lack of this information was due to incomplete printing of the clinical records. Concerning the practice policies as presented, they seem appropriate but I have not made any formal assessment of these given the satisfactory resolution of my concerns. I am also reassured by the correspondence that the doctors had access electronically to the Map of Medicine during [Mr A's] presentations. I cannot comment on the quality of that access.

2. A response to [Dr E's] report, in particular, but not limited to, please provide a response to his comment that

a) the coccydynia diagnosis was reasonable and a time-frame of approximately 6 months is reasonable to wait before considering other diagnoses;

In consideration of [Dr E's] report, I note that there was never a diagnosis made in the clinical records of coccydynia, but rather one of an injury to [Mr A's] coccyx, a trivial matter but it is important to reflect the records as presented rather than changing wording. Coccydynia is Latin for a painful tailbone.

On the time frame, six months may be an acceptable duration to wait for coccyx pain symptoms to resolve assuming the cause was injury but it does not absolve a doctor of a duty to consider other diagnosis to account for [Mr A's] problems when he also presented with additional symptoms in the same body region, particularly the four times in 18 days in March/April of 2018.

[Dr E's] report contains useful references to research papers concerning the accuracy of a digital rectal examination (DRE) for detection of colo-rectal cancer. Key to applying research to [Mr A's] case is whether the patients in the studies are consistent with [Mr A's] circumstances, being one of [a man in his eighties] presenting a number of times over eight weeks with pain in the region of his coccyx along with alterations in his bowel motions. [Dr E] points out rectal pain was not reported in the studies as a presenting problem although it was reported in his reference number 4, [Dr C] and […]. The studies he quotes are retrospective, did not look at the time duration of symptoms or the frequency of visits. The key question to be answered in [Mr A's] case is whether a doctor should have performed a rectal examination based on [Mr A's] presentation with a history of coccyx area pain and the change in in bowel motion at visits 3–6. The research provided by [Dr E] does not answer this question.

Associated with this is that research on the utility of DRE as a screening test (as per [Dr E's] letter page item 5 paragraph 4) is not applicable to [Mr A's] case as he was symptomatic and thus not a 'screening' situation.

b) There is uncertainty regarding the use of Map of Medicine and Health Pathway in [the] region;

According to information presented the Map of Medicine was available until mid 2018. […] confirmed to me by email that

> **'The Map Of Medicine website remained available to GPs to view until after Health Pathways became the favoured and promoted option from 2nd of July 2018'.**

Thus there is no uncertainty that, as of March/April 2018, Map of Medicine was in use and available to the GPs.

As far as the actual usage of the Map of Medicine, I do not have access to data on the website's analyticals. While the printed information provided to me on the Map of Medicine is useful, I cannot comment upon its utility without having full computer access to them.

c) [Dr D] was convinced that the problem was constipation and 3 weeks wait for the next appointment might have been reasonable;

Any conviction on [Dr D's] part that constipation was the cause of [Mr A's] bowel symptoms is by no means certain. His plan documented in the medical records was to exclude sub-acute small bowel obstruction by requesting blood tests and an abdominal xray on his 3 April consultation with [Mr A]. I note that [Dr E] in his report introduced the concept of [Dr D's] conviction on constipation.

Concerning the time frame of three weeks used by [Dr D], to expect a patient with uncertain constipation and possible sub acute bowel obstruction to wait three weeks for a bulking laxative medication (KonsylD) to work is unreasonable as is to wait three weeks for a review visit for test results when the investigation results were available within a few days. Patients suffering from sub acute bowel obstruction usually need relatively urgent hospital care and sometimes abdominal surgery, with some significant abdominal pathology including colorectal cancer causing the condition.[iv]

[Dr D's] statement in his letter of his personal policy of not performing a rectal examination on a patient with three weeks of diarrhoea because it might be infectious, is not consistent with a conviction that the problem was constipation. Additionally, it is a rationale I have never encountered in 43 years of practice and for which I cannot find any supporting research.

Furthermore, while [Dr D] clearly knew of [Mr A's] tailbone injury and his four prior presentations to the medical centre when he saw him 3 April 2018 as emphasised in his 22 August statement in the [Medical Centre 1] letter, he does not appear to have considered that the tailbone pain and bowel changes could be related. This is an important omission both for him and also doctors [Dr B] and [Dr C] for two reasons. One is that additional symptoms increase the predictive value of any examination or test such as a rectal examination. The other is the reliance on the diagnosis of injury to

account for [Mr A's] pain. The process of differential diagnosis is central to good medical practice, as every doctor must consider that a diagnosis other than the most obvious or the first they make, may account for a patient's presentation. [Dr B] acknowledges this in his letter on page one of his 22nd August letter.

Uncertainty is common in medicine, more so in general practice. In [Mr A's] case a diagnosis other than coccyx injury should have been considered given his additional symptoms, his symptom duration, his frequent multiple presentations and the fact that there are important structures such as the anus and rectum immediately adjacent to a patient's coccyx, structures that when examined by [Dr F] revealed a cancer.

d) Any delay in referral is reasonable because of the mixed or equivocal picture of rectal cancer in [Mr A's] case;

e) The doctors acted reasonably within the guidelines in relation to the referral for a colonoscopy

I have revised my opinion on the delay in referral because of the apparent lack of a direct access colonoscopy at [the DHB], the problems with the manner in which the Map of Medicine presents its advice to GPs and the unknown manner in which the DHB surgical outpatient referral triage process functions. Thus establishing a clear standard to judge any delay is problematic.

f) The actions of the doctors fell within a reasonableness test and no finding should be made of a departure from a reasonable standard of care.

Please see my comments below.

3. Any further comments or amendment to your [advice] following their responses.

a. [Dr B]

I note that [Dr B] in his reply letter dated 22 August 2019 accepts that an

'alternative explanation for [Mr A's] coccygeal pain should have been considered.'

His belief that I misunderstood the date when [Mr A] suffered the fall that injured his tailbone is a misreading of my report of 21-05-19, for at no point do I state a belief as to which account of the date of injury I believed. However I have considered [Mr A's] case using the ACC form date, for I consider this the best documentation of a date. If I was to use the December date as per [Mrs A's] account, this would weigh further against the [Medical Centre 1] doctors.

The lack of documentation in the [Medical Centre 1] notes of anal or rectal pain, particularly on [Mr A's] 3 and 5 April consultations at the [Medical Centre 1], is inconsistent with [Mrs A's] account, [Dr F's] recording one week later of '*pain in his anus for the past 5 weeks'* and his phone verbal comment to yourself on 28-06-19 that '*[Mr A] was in such immense pain at the first visit that he arranged for another visit'* in order to perform the appropriate rectal and proctoscope examination.

[Dr B's] comments in the letter that neither rectal nor anal pain were documented by any of the doctors at [Medical Centre 1] indicates an excessive reliance on a patient's ability to differentiate the locality of pain arising from the perineal region in any of three different locations that are less than 3cm from each other in the case of the anus and the coccyx and a lessor distance between the coccyx and the rectum. The labels coccyx, anus and rectum are terms doctors use but patients usually do not have the same discriminatory anatomical knowledge. Further emphasising that a doctor should think of the region rather than the discrete structures is [Dr E's] use of the term 'rectal pain' rather than 'coccyx pain' when appraising the research on the utility of a DRE. Thus a doctor should not totally rely upon a patient's verbal description of pain locality and, as [Dr B] stated, an alternative diagnosis should have been entertained.

When this is added to the presentations to [Dr B] with bowel symptoms on 19 March and 5 April the need for alternative diagnosis is even greater and a pathology in the regions of the body immediately adjacent to the coccyx, namely the anus and rectum, should have been considered.

Thus I do not change my opinion that [Dr B's] care for [Mr A] was a moderate departure from an acceptable standard of care.

b. [Dr C]

In consideration of her explanations on page four of the [Medical Centre 1] letter of 27 August, I am inclined to find her care for [Mr A] reasonable although her failure to verify [Dr B's] coccyx examination findings from five days prior was a mistake, as was her decision to not perform a rectal examination. Differentiating her care from that of [Dr D] is the fact that [Dr D] saw [Mr A] 10 days later.

c. [Dr D]

In addition to my comments above, I note the comment by [Dr E] that

'it is not clear that a direct to colonoscopy route is available in [the area]'.

I cannot verify the existence of such a referral pathway for GPs in [the region] at the time of [Mr A's] problems and in appraising the Map of Medicine pathways as presented to me on paper, I cannot identify any such pathway and the criteria for referral are not clear. I also accept [Dr D's] explanation concerning the Map of Medicine pathway. Thus I revise my initial conclusion on [Dr D's] care for [Mr A] and I no longer find his decision to delay referral to be a departure from an acceptable standard of care.

I do find, as above, that his asking [Mr A] to wait three weeks for a review following his xray and blood tests for a possible sub acute bowel obstruction and bulk laxative therapy, along with his reasoning for not performing a rectal examination, to be unreasonable. This is a mild departure from an acceptable standard of care.

4. *Whether the error identified by you was due to any systematic failure/issues at [Medical Centre 1] or whether it was more attributable to the individual doctor*

I do not find any evidence that there was a systematic failure at [Medical Centre 1]. The failure was that no doctor, until [Dr F], adequately examined [Mr A] to account for his persistence of coccyx region pain and his alteration in bowel motions.

Any other matters in this case that you consider warrant comment.

[Dr E] and [Dr D] highlight some important inconsistencies between the Health Pathways, and the Map of Medicine and an apparent uncertainty in the referral access processes in [the DHB] that should be explored, given their importance both as advice to general practitioners on referral criteria and also the manner in which they are used. These appear to be significantly different from the same processes used here in the Nelson Marlborough DHB region. Pathways are the best easily accessed standard of care advice available to general practitioners but are somewhat inconsistent standards, including sometimes not being consistent with research evidence. I am not aware of any overarching national quality assurance of the pathways nor of the DHB referral triage processes.

I note all the doctors concerned, except [Dr F] but also including [Dr E], mention the bowel screening program and screening tests in their submissions on [Mr A's] case.[15] This is a flaw in thinking for [Mr A's] case was not one of screening but of diagnosis based on symptoms, a very important distinction. Any results from the National Bowel Screening program should not be factored in when a patient presents with symptoms possibly due to colo-rectal cancer.

Perhaps the tragedy of this case is that it appears the wisdom in one of the key messages of the Suspected Cancer in Primary Care Guidelines (a guideline developed by an expert team of general practitioners) was not heeded:

For a person presenting with the same symptoms, or symptom complex, three or more times, a practitioner needs to exclude cancer, and referral to a specialist must be considered.[v]

I trust this opinion aids the Commissioner in his findings.

Yours sincerely

Dr GHJ Vause
MBChB FRNZCGP (Dist) DipGP"

[15] [Dr D also did not mention the bowel screening programme in his responses to HDC.]

The following further advice was obtained from Dr Vause:

> "…
>
> My original advice was intended for [Dr B's] reflection and I noted his denial of any need to consider a change in his clinical behaviour. His reply did not address why he had just placed his clinical notes into the referral without the refinements that would facilitate an appropriate triaging of the referral by the hospital. I am aware that [the] DHB has an eReferral (electronic referral) system for GPs which I suspect was in use at the time of [Mr A's] referral but I cannot confirm this. [Dr B] mentions a template but does not provide any further information on the nature of the template, its source and how it was utilised other than to produce a letter. Whether this was printed hard copy or electronic he has not explained.
>
> Irrespective of whether an eReferral system was used or an internal template within Medtech does not address the fact that the clinical information provided in the letter appears to be a simple copy and paste of his clinical notes as opposed to a structure letter intended to adequately inform the recipient triage clinician.
>
> I acknowledge that the workflow of an eReferral system can influence strongly how a GP might structure the information he/she provides in a referral. Unfortunately in this case I cannot assess this.
>
> Thus my original comments are unchanged by [Dr B's] response.
>
> **Dr GHJ Vause**

[i] Sauter M, Keilholz G, Kranzbühler H, Lombriser N et al Presenting symptoms predict local staging of anal cancer: a retrospective analysis of 86 patients. BMC Gastroenterology, 2016, Volume 16, Number 1, Page 1. Available online at https://doi.org/10.1186/s12876-016-0461-0

[ii] https://en.wikipedia.org/wiki/Coccyx_fracture
https://www.webmd.com/fitness-exercise/tailbone-coccyx-injury#2

[iii] https://oldgp16.rnzcgp.org.nz/assets/Foundation-Standards-Interpretation-Guide-APR-2016.pdf

[iv] Amit Ojha, Anjani Jalaj, Shaleen Tiwari, Vikram Mujalde, Prasheel. 'Diagnosis and Management of Subacute Intestinal Obstruction: A Prospective Study'. Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 26, June 30; Page: 7326-7340, DOI: 10.14260/jemds/2014/2898

[v] Suspected Cancer in Primary Care. Guidelines for investigation, referral and reducing ethnic disparities. © Ministry of Health 2009 Available online at https://www.health.govt.nz/publication/suspected-cancer-primary-care-guidelines-investigation-referral-and-reducing-ethnic-disparities"