General Practitioner, Dr D

General Practitioner, Dr E

A Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC00203)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 15 August 2011, Mrs A, then aged 81 years old, consulted locum general practitioner Dr D at a medical centre (Medical Centre 1), complaining of tiredness. Mrs A had had a right hemicolectomy for bowel cancer in the 1990s. Blood tests reported on 16 August 2011 showed that Mrs A had anaemia, and Dr D prescribed oral iron and referred Mrs A to the surgical outpatient clinic at the public hospital for a colonoscopy.[1] Dr D did not set a reminder on his Task Manager on Medical Centre 1's Patient Management System (PMS) for the results of the colonoscopy.

2. On 19 August 2011, Mrs A's whānau requested that Mrs A instead be referred privately for a CT colonography.[2] Dr D was not working that day, so Dr E (who was Mrs A's usual doctor at Medical Centre 1) initiated the referral. Dr E noted the referral in Mrs A's clinical records, but did not communicate to Dr D the change in Mrs A's management plan, and did not set a reminder on his Task Manager on the PMS for the results of the CT colonography.

3. On 9 September 2011, Mrs A underwent a CT colonography at a radiology service. The CT colonography identified a tumour in Mrs A's colon. Mrs A was not informed of the result of her CT colonography until 21 December 2011.

4. There were a number of contributing factors to the delay in Mrs A receiving the result of her CT colonography: Dr D and Dr E did not follow up their referrals; the radiology service sent the result electronically to Dr E at his old address at another medical centre (Medical Centre 2); Medical Centre 2 advised that the result was forwarded to Dr E at Medical Centre 1, but Medical Centre 1 advised that the result was not received; despite contact from Mrs A and her whānau asking after the result, Medical Centre 1 staff did not follow up the result; and Mrs A recalled that she was told by a Medical Centre 1 staff member that "everything was fine".

5. On 2 November 2011, Mrs A consulted Dr D complaining of pain in her throat and upper arm. Dr D recalled that he asked Mrs A about the result of her colonoscopy, and that she advised him that the results were negative. He said that he was not told that instead of a colonoscopy, a CT colonography had been done privately. Dr D did not check the notes before or during that consultation.

6. Blood tests on 3 November 2011 and 19 December 2011 showed that Mrs A had persistent anaemia. On 19 December 2011, Mrs A contacted Medical Centre 1 for a prescription for oral iron. Dr F was asked to write the prescription. On checking Mrs A's notes, he asked a nurse to trace the CT colonography results, as he was concerned about Mrs A's persistent anaemia. The result was received at Medical Centre 1 on 20 December 2011, and on 21 December 2011 Mrs A was informed of the results and referred to a surgeon.

7. General practitioners who refer patients to a specialist have a responsibility to take reasonable steps to follow up the referral. That duty is clearly established in both the

[1] Colonoscopy is a procedure that uses an endoscope to view the large bowel and the distal part of the small bowel.
[2] CT colonography uses CT scanning to obtain images of the colon. This is a non-invasive procedure.

Medical Council of New Zealand's professional practice guidelines and in previous HDC opinions. In my opinion, Dr D, Dr E, and Medical Centre 1 did not take reasonable steps to follow up their referrals. Therefore, Mrs A did not receive services with reasonable care and skill, and Dr D, Dr E and Medical Centre 1 breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights 1996 (the Code).[3]

Complaint and investigation

8. The Commissioner received a complaint from Ms B about the services provided to her mother, Mrs A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by Dr D between August and November 2011.*
- *The appropriateness of the care provided to Mrs A by Dr E between August and December 2011.*
- *The appropriateness of the care provided to Mrs A by Medical Centre 1 between August and December 2011.*

9. An investigation was commenced on 15 February 2013.

10. This report is the opinion of Deputy Commissioner Ms Theo Baker, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant and Mrs A's daughter
Ms C	Complainant and Mrs A's daughter
Dr D	Provider, general practitioner
Dr E	Provider, general practitioner
Medical Centre 1	Provider

Also mentioned in this report:

Dr F	General practitioner
Medical Centre 2	Dr E's previous medical centre
A radiology service	
Ms G	Manager at Medical Centre 1
Dr H	Public hospital GP liaison
Dr I	Surgeon

12. Information was also reviewed from the radiology service and Medical Centre 2.

[3] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

13. Independent expert advice was obtained from general practitioner Dr David Maplesden.

Information gathered during investigation

Background

14. On 15 August 2011, Mrs A, then aged 81 years, consulted locum general practitioner Dr D at Medical Centre 1[4] complaining of tiredness. Dr D commenced Mrs A on oral iron, ordered blood tests, and referred her to the surgical outpatient clinic at the public hospital for a possible colonoscopy. Mrs A had had a right hemicolectomy for bowel cancer in the 1990s,[5] following which she had received chemotherapy.

15. Mrs A's blood test results were reported on 16 August 2011, and showed that she had anaemia. The referral letter (dated 18 August 2011) to the Surgical outpatient clinic at the public hospital stated:

> "Thank you for seeing [Mrs A] who presented today with iron deficiency anaemia and a hemaglobin of 81. She has a history of colon cancer 18 years ago and underwent a bowel resection. In light of the iron deficiency, there is a concern for recurrence of carcinoma and she may be in need of a colonoscopy."

16. At the time of these events, Medical Centre 1's Test Results policy required:

> "All test results, referrals or requests deemed urgent or of high importance by the clinical staff are added to the Provider Task List. The details of the result, referral or request will be lodged by the Doctor or the Nurse into the 'Task Manager' function in Medtech."

17. Dr D advised HDC that he did not set a reminder on his Task Manager at the time of Mrs A's referral, because he did not know that this could be done. In response to my provisional opinion, Dr D advised that prior to commencing work at Medical Centre 1 he went through a comprehensive orientation programme that included training in the use of MedTech. However, Dr D said that previously he had never used an electronic medical record system, and he acknowledges that he failed to utilise its functions correctly.

18. Dr D advised HDC that he did not expect the colonoscopy report to be received in his Inbox "very soon", because such investigations can take some time.

[4] Dr D worked as a locum at Medical Centre 1 from June to November 2011, and is originally from overseas. Mrs A's usual doctor at Medical Centre 1 was Dr E; however, Dr E was on leave on 15 August 2011.

[5] It is unclear exactly when in the 1990s Mrs A was diagnosed with, and received surgery for, her bowel cancer. In the information provided to HDC by various parties, including the clinical records, it is variably referred to as having been in 1996, 1998 and 1999, and, in a referral letter written by Dr D on 18 August 2011, it is referred to as having occurred "18 years ago".

19. Mrs A's daughter, Ms B, advised HDC that in August, two of her sisters accompanied their mother to Medical Centre 1 and asked to be contacted if there were concerns regarding their mother's health. The reason for the request was that because Mrs A lived alone, with her nearest family living in another area, they wanted to ensure there would be someone available to accompany Mrs A to her appointments to support her, and so that they could have an understanding of her health status.

20. On 19 August 2011, Mrs A's whānau contacted Medical Centre 1 and requested that Mrs A be referred privately for a CT colonography. Dr E responded to the request. He recalled that Mrs A's whānau requested the change because a previous colonoscopy had been very painful for Mrs A, and they thought that a CT colonography would be less painful. Dr E advised HDC that, in the usual course of events, Dr D would have initiated the referral requested, to ensure continuity of care. However, as Dr D was not working that day, Dr E was asked to initiate the referral. Dr E wrote the referral on 22 August 2011.

21. The referral was noted in Mrs A's Medical Centre 1 records. Dr E did not personally communicate to Dr D the change in Mrs A's management. Dr E did not set a reminder on his Task Manager of Mrs A's referral. He advised HDC:

> "Because the family of [Mrs A] [were] taking responsibility for having the investigation done privately, I did not set a reminder on my task manager in Medtech. The high level of family support and their decision to undertake private medical treatment assured me that they would quickly follow up on medical test results."

22. On 9 September 2011, Mrs A underwent a CT colonography at the radiology service. The report of the colonography recorded the following finding:

> "There is an 'apple core' constricting colon tumour in the proximal colon just distal to the caecum which is in the subhepatic location. The distal end of the tumour is 141cm from anal verge. It measures approximately 5cm maximum length is seen to encircle the colon completely. … There is a further, smaller mucosal lesion seen in the proximal descending colon just distal to the splenic flexure, 112cm from the anal verge. This looks like a small polyp, 13mm in diameter."

23. This means that there was a tumour encircling part of the colon underneath the liver. A further smaller lesion was also seen in the proximal descending colon.

24. The radiology service sent the result of the CT colonography electronically to Dr E. The address that the radiology service had on its system for Dr E was his old address at Medical Centre 2 and, accordingly, Mrs A's CT colonography result was sent there. The referral from Dr E was written on Medical Centre 1 letterhead, but the copy that the radiology service received via fax appears to have cut off the top of Dr E's letter.

25. The result was acknowledged electronically as being received at Medical Centre 2 at 7.30am on 12 September 2011. Staff at Medical Centre 2 advised that the result was printed off and posted to Dr E at Medical Centre 1. However, the result was never

received at Medical Centre 1. Ms G, the Manager at Medical Centre 1, recorded in Mrs A's notes on 22 December 2011, after it had been identified that the result had not been received:

> "CT Colonography result sent to [Medical Centre 2] in September. I phoned and spoke to the Practice Manager today and she found the result in an inbox. Results are normally forwarded on but this did not happen in this case."

26. Ms B advised HDC that, on 10 September 2011, Mrs A received in the mail copies of the CT colonography images and a CD. Ms C advised HDC that on 12 September 2011 she telephoned Medical Centre 1 twice for the results, and was told on both occasions that the results had not been received. There is no record of Ms C's calls to Medical Centre 1 in Mrs A's records for 12 September.

27. On 13 September 2011, Mrs A contacted a practice nurse at Medical Centre 1, and advised that she had received the CT images in the mail with no accompanying letter, and would bring them in on 14 September.

28. On 13 September, Ms C again contacted Medical Centre 1 for the results and was told that they had not been received. Ms C then contacted the radiology service, and was told that the results had been sent. On the same day, it is recorded in Mrs A's records at Medical Centre 1 that her daughter "rung for results".

29. Mrs A took the disc and pictures that she had received in the mail from the radiology service to Medical Centre 1. Mrs A advised HDC that she was unsure to whom the disc and pictures were given at Medical Centre 1. There is no documentation in Mrs A's Medical Centre 1 records regarding that visit, and Medical Centre 1 advised HDC that Mrs A "did not drop off the CD to us the next day as she said she would".

30. Mrs A subsequently presented at Medical Centre 1 to request her results and collect the CT images. Mrs A told HDC that she recalls that Dr D came out with the CD and told her that "everything was fine"; however, Ms B said that Mrs A had told her it was a nurse she had spoken to. There is no documentation of that visit in the clinical records, and no Medical Centre 1 staff recall Mrs A presenting on that day. Medical Centre 1 Manager Ms G advised HDC that she is "quite sure" that no staff told Mrs A that she had a normal result, and Ms G noted that no nursing or administrative staff at Medical Centre 1 can interpret scans and pictures. She stated: "I cannot comment further why [Mrs A] might have been given the impression she had a normal result." Dr E advised HDC that when he spoke to Mrs A on 21 December 2011, she said that she was told that the result was normal, but she could not remember which nurse had told her that.

31. Ms B recalled that Mrs A called her children on 16 September 2011 and "told [them] the good news".

32. On 29 September 2011, the public hospital's GP Liaison Dr H wrote to Mrs A to advise that because the "colonoscopy" had been performed privately, and she no longer required an appointment at the public hospital's surgical outpatient clinic, her name had been removed from the waiting list. The letter was copied to Dr D at

Medical Centre 1, and it is recorded in Mrs A's Medical Centre 1 records that the letter was received on 5 October 2011.

33. On 2 November 2011, Mrs A presented to Medical Centre 1 complaining of pain in her throat and left arm with exertion, which was "relieved with rest and is associated with sweating". She saw Dr D, who asked her about the result of her colonoscopy. Mrs A advised Dr D that the "colonoscopy" was negative, and he advised HDC that he had no reason to question that because patients who have had a colonoscopy will receive the results of the study the same day. Dr D advised HDC that Mrs A did not tell him that a CT colonography had been done privately. He said that, at that visit, Mrs A wanted to talk about her cardiac condition and not her referral for colonoscopy/CT colonography. Dr D said that, had he known that a CT colonography had been substituted for the initial colonoscopy, he may have "looked further into the matter" because "radiology results are not usually obtained by the patient directly from the radiologist". However, he advised that his "tendency is to believe what a patient tells [him] regarding results of such tests".

34. There is no mention in Mrs A's Medical Centre 1 records of Dr D's conversation with Mrs A about her results. Dr D did not check the results himself.

35. Dr D referred Mrs A for blood tests and an exercise stress test for her presenting complaint of left arm pain. He wrote the referral for the exercise stress test on 2 November 2011, and noted in the referral letter, "… had a colonoscopy two months ago to work up the anaemia in light of her history of colon cancer. This was done privately."

36. The exercise test result was normal. The blood tests were taken on 3 November, and the results received at Medical Centre 1 that day. The results showed that Mrs A had persistent anaemia, and those results were reviewed by Dr D, who prescribed oral iron therapy and recommended repeat blood tests in six weeks' time. Dr D advised HDC that, in light of what he considered to be Mrs A's negative colonoscopy, he was concerned about her persistent anaemia; however, Mrs A advised him that she had stopped taking the earlier prescribed oral iron therapy after she had been told that her results were normal.[6] Dr D advised HDC: "I did review the chart in order to look for the result, however there was no report to be found … I assumed the report was either slow to be sent over, or that private physicians did not routinely send their results to the public health GPs." Dr D also submitted that it was the letter from Dr H, "which referred to the privately done colonoscopy which was negative that I determined that [Mrs A's] test was indeed negative".[7] Further blood tests taken on 19 December showed that Mrs A had persistent anaemia.

37. On 19 December, Mrs A contacted Medical Centre 1, requesting a new prescription for iron tablets. Dr F was asked to write the prescription. On checking Mrs A's notes, he asked a nurse to trace the colonoscopy results, as he was concerned about Mrs A's persistent anaemia. The radiology service was contacted on 20 December and Mrs A's

[6] That discussion was not recorded in Mrs A's contemporaneous records for that visit.

[7] Dr H's letter does not say that the result was negative. His letter states: "Thank you for your phone call informing us that you have had your colonoscopy done privately and that you no longer require this appointment. I am writing to confirm that your name has been removed from the Outpatient Clinic waiting list and a copy of this letter has gone to your GP."

results were faxed through that day. Dr E contacted Mrs A that evening and asked her to come in the following day.

38. On 21 December, Mrs A was seen by Dr E and informed of the test results, and a referral was made to a surgeon.

39. Mrs A consulted surgeon Dr I on 22 December 2011. Dr I noted that Mrs A had no symptoms other than low haemoglobin, including no abdominal pain and no change in bowel habit. Dr I also noted that, on examination, Mrs A was generally well. Dr I recommended a colectomy to remove the tumour, and placed Mrs A on his urgent waiting list. The surgery was performed early in 2012.

Additional information

The radiology service

40. The radiology service advised HDC that it accepted responsibility for having the wrong address for Dr E. It advised that although the referral form did not include an address or refer to Medical Centre 1, the referral form referenced an attached letter, which was not scanned onto its system. Because the attached letter was not scanned onto the system, the radiology service was unable to determine whether the letter had included Dr E's new address at Medical Centre 1; however, the radiology service noted that front line staff are responsible for checking details and would normally refer to the referral form, so any discrepancy in address in the attached letter should have been identified.

41. The radiology service also advised HDC that it had apologised to Mrs A through Ms C for that error, and that the examination had been fully refunded. The radiology service also advised HDC that it had investigated the matter. It noted that general practitioners changing medical centres is a "constant problem", and that it was undertaking to audit "the thousands of addresses regularly that reside in [its] system", but that it is reliant on general practitioners advising of changes to their contact details.

42. The radiology service advised that it has taken the following action to prevent a similar event recurring:

- a genuine attempt will be made in the future to ensure that adverse results will be phoned through to the referring GP;
- staff have been reminded to check and double check referrer names and addresses as part of the process of entering the patient onto the Radiology Management System (the RMS);
- administration staff receiving any calls regarding non-delivery of results now make a diary note and report that to the office manager, who will then investigate any report of non-delivery to determine whether there has been a breakdown in the delivery system;
- three senior managers have responsibility for ensuring any changes in the RMS are double-checked, especially the electronic data identifier; and

- regular audits of referrer details are undertaken.

Medical Centre 1

43. Medical Centre 1 advised HDC that Dr D spent three days on an orientation course before he commenced work at Medical Centre 1. Dr D confirmed that during this orientation he was shown how to use MedTech and its functions. On his first day at Medical Centre 1 (20 June 2011), he had no patients booked. Dr D met with his supervisor, Dr F, and with Dr E and Ms G. He also met with the nurses and other staff, and was given a locum folder to review, which included "all information relevant to the practice", including the Test Results Policy and information on the Code of Health and Disability Services Consumers' Rights 1996. Medical Centre 1 advised that it does not formally document the outcome of the orientation and check that the doctor has read the documentation. Medical Centre 1 also advised that, as a result of the complaint, it is developing a more robust orientation for locums, which will be signed off by the locum and followed up by the manager to ensure it is done.

44. Ms G advised HDC:

> "We have met as a team and discussed this as a significant event. We are sincerely sorry for any part we played in the delay in [Mrs A's] treatment and feel that she was let down by a series of mistakes and misunderstandings by other health providers as well as ourselves … I believe one of our staff should have phoned the radiology service in September when we were asked by the family for the result. We have reviewed our procedures and put guidelines in place to ensure this happens in future."

45. The notes of the Significant Event Meeting on 8 February 2012 record that the following changes were made to the Test Results Policy:

- the locum should meet with his/her supervisor to "hand over" prior to leaving the practice;
- staff should not rely on patients to present their results when they have not been sent through to Medical Centre 1, but should phone for the results directly;
- staff members should be aware of the policy and report to a staff meeting if any changes are required, or if the policy has not been followed; and
- any results that a doctor considers may be a "red flag", even if the patient is being treated privately, should be moved to the GP task list to allow follow-up.

46. Medical Centre 1 also advised HDC that a change has been made to the Test Result Policy to ensure that, if test results are not available when a patient telephones to enquire, the nurse will be responsible for chasing the result if a reasonable time has passed since the test (for example, five working days).

47. On 20 March 2012, Ms B and her sister met with Medical Centre 1 staff, including Dr E. Dr E advised HDC that, at that meeting, he explained the process of diagnosis, intervention and where, in his view, the issues arose. Dr E advised HDC that he assured the family that the team had met to discuss the issues surrounding the delay in

obtaining Mrs A's CT colonography result, and that it had taken steps to ensure that such a delay would not occur again.

48. Dr E advised HDC that he regrets not setting a reminder. In response to my provisional opinion, Dr E reiterated that since this complaint Medical Centre 1 has reviewed its system and there is now a "more robust system in place with appropriate reminders to follow up on referrals, to minimise the risk of such error occurring again".

Dr D

49. Dr D advised HDC that, in the future, he will "be more careful when making inquiry of patients regarding test results, [realising] that changes of which I am unaware can take place between office visits". Dr D also submitted that once Mrs A had cancelled the colonoscopy referral and decided to have a colonography, "she effectively removed herself from [his] care as her physician for this problem".

50. In response to my provisional opinion, Dr D accepted that he is ultimately responsible for the follow-up of a patient's results when he initiates an investigation. However, he provided two explanations for why he did not follow up Mrs A's referral in this case. He first advised that he was not familiar with the New Zealand medical system at the time and that he assumed that, as he says is the case in his home country, by referring Mrs A for the colonoscopy her care would be managed and followed up by the provider he referred her to, which in this case was the public hospital. He subsequently advised that he now recalls a conversation with two of the practice nurses during which he was advised that Mrs A had "taken her problem to [Dr E], her primary doctor" and that the results of the tests would be sent to Dr E. Medical Centre 1 advised HDC that no one can recall this conversation with Dr D.

51. In response to the provisional opinion, Dr D accepted that his clinical records were inadequate. He advised that he now ensures that he documents a more comprehensive record of his assessment and management plan. In addition, Dr D advised that since this complaint, he has made it a priority to learn how to use and rely on a PMS such as Medtech.

Opinion

Introduction

52. Mrs A was not informed of her test result in a timely manner. The test result slipped through the cracks because of poor communication and coordination between all of the providers involved in the management of the result. In this case, a series of errors, including individual failures and systems issues, compromised the protections that should have been in place. As a result, Mrs A did not receive the care to which she was entitled.

53. This report is concerned with the individual responsibilities of Mrs A's general practitioners, and the systems issues associated with Medical Centre 1.

54. General practitioners who refer patients to a specialist have a responsibility to take reasonable steps to follow up the referral. The duty to follow up referrals is clearly established in both the Medical Council of New Zealand's professional practice guidelines and in previous HDC Opinions.[8] When referrals are not followed up, the continuity of care provided to a patient is compromised, and the patient may be harmed.

55. The Medical Council of New Zealand publication *Good Medical Practice* (June 2008) contains a supplementary guidance section on referring patients, which provides that doctors "must also have a process for identifying and following up on overdue results". In addition, *Good Medical Practice* states, at paragraph 52: "If you are the patient's principal health provider, you are responsible for maintaining continuity of care."

56. As the primary care provider, general practitioners are responsible for the day-to-day clinical management of their patients, and an important aspect of care is the follow-up of referrals and test results. As stated in Opinion 07HDC20199:

> "GPs have a key role to play in following up referrals to check that they are actioned promptly. For most patients, their GP is the health care provider who is best placed to keep an overview of their care. … An aspect of this duty is actively following up a referral for a patient who is still awaiting a further specialist assessment. … I consider that the GP retains a residual responsibility to monitor the progress of the patient through the system."

57. Several tools are available to assist general practitioners to meet their obligations to follow up on patient referrals, none of which used in this case. For example, as the Commissioner has previously noted:

> "One simple precaution providers can take to ensure referrals are being actioned in a timely manner is to allow for automatic alerts to appear on their computer screen at a nominated interval after a referral letter has been generated, alerting them to follow up if they have not heard back from the clinician by that time …"[9]

58. Dr D, Dr E, and Medical Centre 1 did not take reasonable steps to follow up on their referrals. As a result, Mrs A was not informed of her test result in a timely manner, and her care was compromised. In my opinion, for the reasons set out below, Dr D, Dr E and Medical Centre 1 failed in their responsibilities to Mrs A and breached the Code.

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[8] See, for example: 10HDC01419, 10HDC00454, 08HDC06359, 08HDC06165, 07HDC20199, 05HDC14141, 04HDC13909 and 01HDC04864.
[9] See: "Referrals trip up GPs and DHBs", *NZ Doctor* (October 2012), available at: www.hdc.org.nz.

Breach — Dr D

59. On 15 August 2011, Mrs A consulted locum general practitioner, Dr D, at Medical Centre 1, complaining of tiredness. Dr D commenced Mrs A on oral iron, ordered blood tests and referred her to the surgical outpatient clinic at the public hospital for a possible colonoscopy. I accept Dr Maplesden's advice that Dr D's overall clinical management of Mrs A at this point was consistent with expected standards, in that her iron deficiency anaemia was being investigated appropriately. However, I note Dr Maplesden's comments regarding the inadequacy of Dr D's clinical notes for this consultation, in that Dr D did not record his planned follow-up and investigation plan. In response to the provisional opinion, Dr D acknowledged that his clinical records were inadequate and that such information is important to facilitate care continuity, particularly when there are locum providers in a practice.

60. Dr D did not use the tools available to him in the PMS to remind him to review the result of the colonoscopy he requested for Mrs A. Dr D advised HDC that he was not aware that he could use Task Manager in the PMS as a means of setting clinical reminders, and therefore he did not set any such reminder for Mrs A's results. Dr Maplesden advised that, in his view, the failure to use a reminder such as the Task Manager for an investigation result that had a significant possibility of being abnormal was a departure from expected standards, but that Dr D's omission "was predominantly due to inadequate orientation processes rather than deficits in Dr D's management per se". In response to the provisional opinion, Dr D acknowledged that he would have been shown how to use the Task Manager function during his orientation.

61. Regardless of his understanding of how to use Task Manager, the duty Dr D owed to Mrs A was to follow up the test results he ordered. Task Manager is a tool that was available to Dr D to assist him to meet that duty; however, any lack of knowledge of the tool or how to use it does not absolve him from his responsibility to follow up the result of the test he ordered for Mrs A. Dr D reviewed Mrs A again on 2 November 2011. In the time between 15 August 2011 and 2 November 2011, the following events had taken place, all of which were recorded in Mrs A's clinical records:

(a) Mrs A's whānau contacted Medical Centre 1 on 19 August 2011 to request a private referral for a CT colonography.

(b) A private referral for CT colonography was initiated by Dr E on 22 August 2011.

(c) On 13 September 2011, Mrs A contacted a practice nurse at Medical Centre 1 and advised that she had received the CT images in the mail with no accompanying letter, and would bring them in on 14 September. On the same day, it is recorded in Mrs A's records at Medical Centre 1 that her daughter had telephoned asking about results.

(d) On 29 September 2011, the public hospital's GP Liaison Dr H wrote to Mrs A to advise that because the "colonoscopy" had been performed privately, and she no longer required an appointment at the surgical outpatient clinic, her name had been removed from the waiting list. The letter was copied to Dr D at Medical

Centre 1, and it is recorded in Mrs A's Medical Centre 1 records that the letter was received on 5 October 2011.

62. Dr D did not read Mrs A's notes prior to or during his 2 November consultation with her. Had he done so, he would have been aware that she had been referred privately for a CT colonography and that the results had not been received. Instead, Dr D asked for, and accepted, Mrs A's advice that she had undergone the colonoscopy, and that the results had been normal.

63. The primary responsibility for following up a test result lies with the clinician who orders the test. Dr D had a responsibility to satisfy himself that the result of the test he ordered had been received, and the nature of the result. It was unwise for Dr D to rely on Mrs A's recollections of her test result without undertaking further enquiries. As noted in a previous report, it is the referring practitioner's responsibility to follow up test results, not the patient's.[10] While it is important for a patient to take some responsibility for his or her treatment and well-being by giving his or her clinicians as full and accurate information as he or she can, as noted in a previous report, "[t]he onus is on the clinician to ask the relevant questions, examine the patient, and keep proper records".[11] It is inappropriate to claim that Dr D's failure to follow up his referral was the result of incorrect information provided to him by his patient.

64. On 2 November 2011, Dr D referred Mrs A to the public hospital for an exercise stress test. The referral letter noted: "… had a colonoscopy two months ago to work up the anaemia in light of her history of colon cancer. This was done privately." Dr D further submitted that, on 3 November 2011, when he received Mrs A's blood results, which showed that her anaemia was persisting, he reviewed Mrs A's chart to look for the result, but that "there was no report to be found". Dr D further advised that he "assumed the report was either slow to be sent over, or that private physicians did not routinely send their results to the public health GPs". If that were indeed the case, and Dr D reviewed Mrs A's notes on 3 November, he would have noted that Mrs A had been referred privately for a CT colonography, and that her results had not been received. Presumably he would also have questioned Mrs A's assumed knowledge of the test results, given his view expressed to HDC that radiology results are not usually obtained by the patient directly from the radiologist. In those circumstances, it was unwise for Dr D to assume that the report was slow, or that private physicians did not routinely send their results to public health GPs. Dr D should have asked his supervisor at Medical Centre 1, Dr F, for clarification on these matters.

65. Dr D also submitted that it was the letter from the public hospital's GP Liaison Dr H "which referred to the privately done colonoscopy which was negative that I determined that [Mrs A's] test was indeed negative". Dr H's letter does not say that Mrs A's test was negative. It is unclear how Dr D could have assumed from the letter that the result was negative and that no further follow-up was required; indeed, the letter referred to a private referral, which should have triggered Dr D to make further enquiries as to the status of his referral, and Mrs A's advice that her result was normal.

[10] See Opinion 10HDC00454.
[11] See Opinion 09HDC01505.

66. Dr D has offered three reasons for not following up on the test results. He submitted that Mrs A did not seem to want to talk about her test results at her 2 November 2011 appointment, and was focused on her presenting cardiac complaint; that once Mrs A had cancelled the colonoscopy referral and decided to have a CT colonography, she effectively removed herself from his care as her physician for this problem; and finally that he had been advised that Mrs A had transferred her care in relation to this problem to Dr E, and that Dr E would be sent the results. I do not accept that Mrs A's care in relation to this issue was no longer Dr D's responsibility. Dr D had ordered a test, and he had a responsibility to follow up on the result and ensure that it was conveyed to his patient, irrespective of her other presenting complaints or the involvement of other clinicians.

Conclusion

67. Seamless patient care requires that clinicians act to ensure their concerns are being appropriately actioned. Dr D did not take sufficient action to follow up on his referral and to assure himself of the outcome of his referral. In my view, Dr D did not provide Mrs A with services with reasonable care and skill, and I find that he breached Right 4(1) of the Code.

Breach — Dr E

68. On 22 August 2011, following a telephone call from Mrs A's whānau on 19 August 2011, Dr E referred Mrs A for a private CT colonography.

69. Dr E owed a duty to Mrs A to follow up on this referral, but he did not do so. Dr E advised HDC that because of the involvement of Mrs A's whānau, he did not set a reminder on his Task Manager, assuming that the whānau would follow up the results.

70. The primary responsibility for following up a test result lies with the clinician who orders the test, not the patient.[12] While it is important for a patient to take some responsibility for his or her treatment and well-being by giving his or her clinicians as full and accurate information as he or she can, as stated in a previous report, "[t]he onus is on the clinician to ask the relevant questions, examine the patient, and keep proper records".[13] Dr E had a responsibility to satisfy himself that the result of the test he ordered had been received, and to ensure appropriate communication and follow-up of that result. He failed to do so in this case.

71. By failing to follow up on the result of a test he ordered, Dr E failed to provide Mrs A with services with reasonable care and skill, and breached Right 4(1) of the Code.

[12] See Opinion 10HDC00454.
[13] See Opinion 09HDC01505.

Breach — Medical Centre 1

72. I have concerns about the standard of care Medical Centre 1 provided to Mrs A in this case.

73. There is a discrepancy in Medical Centre 1's account of events following Mrs A's CT colonography on 9 September 2011 and the account of events given by Mrs A's whānau. Members of Mrs A's whānau recall that they contacted Medical Centre 1 on 12 and 13 September to enquire after the results of Mrs A's CT colonography. Mrs A recalls that she took the disc and pictures she had received in the mail from the radiology service to Medical Centre 1, and that when Mrs A picked up the CD and images on 16 September 2011 she was informed that "everything was fine". On the other hand, Medical Centre 1's only recorded contact with Mrs A or her whānau was on 13 September. Furthermore, Medical Centre 1 advised that Mrs A did not drop off the CD, and that no staff told Mrs A that she had a normal result.

74. I am not able to resolve the differences in account between Mrs A's whānau and Medical Centre 1. However, even without reconciling those accounts, I am satisfied that Medical Centre 1 missed at least two opportunities to follow up on Mrs A's test result. In particular, there is evidence that Mrs A's daughter contacted Medical Centre 1 on 13 September 2011, enquiring after the result of Mrs A's CT colonography. In addition, on 5 October 2011, Medical Centre 1 received a letter from the public hospital's GP Liaison Dr H to advise that the colonoscopy had been performed privately, and, as Mrs A no longer required an appointment at the surgical outpatient clinic, her name had been removed from the waiting list. These events should have alerted Medical Centre 1 to the fact that Mrs A's results from her CT colonography had not been received, and should have prompted staff at Medical Centre 1 to follow up on those results.

75. Furthermore, the fact that Mrs A had been referred for an investigation by two different doctors, both failing to follow up the results appropriately and in accordance with practice policy, is concerning. This sub-optimal care by more than one clinician reflects a service failing, and brings into question the adequacy of Medical Centre 1's staff orientation.

76. In my view, Medical Centre 1 failed in its responsibility to provide services with reasonable care and skill to Mrs A. Medical Centre 1 missed opportunities to follow up Mrs A's test results. This, coupled with the above outlined systemic failings, resulted in Medical Centre 1 having failed to provide services of an appropriate standard to Mrs A. Accordingly, Medical Centre 1 breached Right 4(1) of the Code.

Recommendations

77. I recommend that Dr D undergo a competency review by the Medical Council of New Zealand should he return to practise in New Zealand.

78. The following recommendations made in my provisional opinion have been complied with:

- As stated, Dr D has reviewed his practice, including his documentation practices to ensure that he now documents a more complete summary of his assessment and management plan;
- Dr D is taking steps to learn how to use electronic medical record systems and the use of functions such as Task Manager to follow up referrals, to minimise the risk of such an error occurring again;
- Dr D has apologised to Mrs A for his breach of the Code;
- Dr E has apologised to Mrs A for his breach of the Code;
- Medical Centre 1 has apologised to Mrs A for its breach of the Code; and
- Medical Centre 1 has agreed to arrange an audit by the Cornerstone accreditation team in relation to documentation (in particular the consultation record), systems for following up referrals, and continuity of care, and report to HDC on the results, by **8 September 2013.**

Follow-up actions

79.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr E's and Dr D's names.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of Dr D's and Dr E's names.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent general practitioner advice to the Commissioner

The following expert advice was obtained from general practitioner Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her mother, [Mrs A], by [Medical Centre 1]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest although, as a [city]-based general practitioner, I do refer patients to [the radiology service]. I have examined the available documentation: complaint from [Ms B]; responses from [Medical Centre 1] and [the radiology service] ([the radiology service]); responses from [Dr D] and [Dr E]; GP notes; clinical documentation from [the public hospital] and [another hospital]. The complaint relates to a three-month delay between [Mrs A] undergoing CT colonography and her being notified of the abnormal result by her GP. In the interim, she had apparently been told by [Medical Centre 1] staff that the result was normal.

2. [Mrs A] had a past history of colon cancer, with surgery in 1999. She had had a previous hip replacement and had apparently had a depressive episode in mid 2011. She presented to [Medical Centre 1] (provider: locum GP [Dr D]) on 15 August 2011 with complaint of *fatigue, thinks she needs iron.* Iron was prescribed and blood tests undertaken with results showing iron deficiency anaemia. On receipt of the results, [Dr D] referred [Mrs A] to surgical outpatient clinic at [the public hospital], noting her past history of colon cancer and *there is a concern for recurrence of carcinoma and she may be in need of a colonoscopy.* Further bloods including the tumour marker CEA were ordered — CEA was mildly elevated at 6.0 ng/ml (normal < 4.0).

Comment: Overall clinical management at this point was consistent with expected standards. The iron deficiency anaemia was being investigated appropriately as colon malignancy was a likely cause given the past history. The clinical notes are mildly suboptimal in that there is no comment in the body of the notes regarding the follow-up and investigation plan. Such information is particularly important when there are locum providers in the practice, to facilitate continuity of care. [Dr D] was an overseas trained doctor working in a locum capacity at [Medical Centre 1] for the period 20 June to 11 November 2011. He had undergone broad orientation to New Zealand general practice via his locum agency, and had had an informal orientation by staff members at [Medical Centre 1] including being informed there was a folder containing practice policies. He was not aware of the use of the Medtech PMS function 'Task Manager' as a means of setting clinical reminders and therefore did not set any reminder to review the colonoscopy result. The failure to use such a reminder for an investigation result that had a significant possibility of being abnormal was a departure from expected standards. However, on this occasion I feel the omission was predominantly due to inadequate orientation processes rather than deficits in [Dr D's] management per se and was, a mild (or, at most, mild to moderate) departure from expected practice under the

circumstances. [Dr D] should ensure he has a good understanding of the capabilities of the PMS, and of expectations regarding handling of investigation results, when he undertakes locum work in the future even if the formal orientation process has not adequately addressed these areas. I have reviewed the [Medical Centre 1] test results policy and this is robust, consistent with expected standards, and does mention use of 'Task Manager' as a means of tracking significant test results. The [Medical Centre 1] locum orientation policy is somewhat less robust, particularly regarding the ability to track details of completion of the process, and formal assessment of the locum's expertise with the PMS. I recommend the practice review its locum orientation process to ensure all orientation modules are completed in a timely fashion and to a satisfactory standard, particularly with respect to PMS expertise.

3. On 19 August 2011 nursing notes record a request from family for [Mrs A] to undergo private CT colonography rather than colonoscopy as they feel she would tolerate this better. Later that day, family provide a name and contact details of [a surgeon] they would like to deal with regarding their mother's management. On 22 August 2011 [Dr E] has provided a referral letter to [the radiology service] requesting CT colonography. The letterhead on the referral clearly identifies the source of the referral as [Medical Centre 1], with EDI listed as […].

Comment: The colonography result was required before referral to the surgeon, and referral was made to the appropriate provider ([the radiology service]) with referrer details prominent on the request form. [Dr E] was [Mrs A's] usual GP and [Dr D] was away at the time the request was made. Given [Dr D] was present at [Medical Centre 1] for a limited term and [Dr E] was [Mrs A's] usual GP, while it may have been professionally courteous for [Dr E] to inform [Dr D] there had been a change in [Mrs A's] management plan (initiated by [Dr D]) I do not think, under the circumstances, the failure to convey this information was a departure from expected standards. [Dr E] did document the change in management in the clinical notes. However, [Dr E], having ordered the colonography under his name, was now primarily responsible for following up the result. He did not use 'Task Manager' to ensure timely receipt and follow-up of the result and this was a mild to moderate departure from expected standards, and a departure from the practice policy. He should ensure appropriate use of such a reminder in the future. However, he states in his response that [Mrs A] and her family were well known to him and he was confident they would enquire after the result as soon as the procedure was undertaken, and he expected this to be an adequate reminder.

4. CT colonography was undertaken at [the radiology service] on the morning of 9 September 2011. Family members accompanying [Mrs A] for the examination were told by [the radiology service] staff that the result would be forwarded to [Mrs A's] GP once it had been verified. [Ms B] states that on 10 September 2011 her mother received by post a disc and images of her examination from [the radiology service]. On 12 and 13 September 2011 a family member ([Ms C]) rang [Medical Centre 1] enquiring after the results and was told on both occasions that they had not arrived. She contacted [the radiology service] on 13 September 2011 and was told the results had definitely been forwarded to the GP. [Ms B] states

the disc and images were dropped off at [Medical Centre 1] by [Mrs A] who contacted the centre over the next couple of days trying to get the result. (There are images on file in [the public hospital] notes which illustrate the abnormalities and include labels of *polyp* and *tumour* but I cannot be certain these were the same images supplied to [Medical Centre 1]). On 16 September 2011 [Mrs A] states she presented in person to [Medical Centre 1] requesting her results and was told by a nurse that *everything was fine.* She passed this good news onto her family. [Medical Centre 1] nurse notes on 13 September 2011 record *has received a CD and 'pictures in the mail from ?specialist. Daughter has also rung for results. If are all ok, have been advised to cancel next spec appt on Tuesday 20th*. There are no further notes until 2 November 2011.

Comment: The [Medical Centre 1] response differs from the recollections of [Ms B] in that there is an assertion there was no contact from [Mrs A] or her family other than that documented, and the disc and images were never dropped off to [Medical Centre 1]. This situation is discussed below in the concluding comments.

5. CT colonography showed a tumour in the proximal colon with a further polypoidal mass just distal to the splenic flexure. There was no evidence of extra-serosal spread or regional lymphadenopathy. [The radiology service] confirms the report was sent to [Dr E] [electronically] on 9 September 2011, using the EDI they had on file for [Dr E]. The report was acknowledged electronically as being received. It was only when [Dr E] requested a copy of the report some three months later that it was realised he had shifted from [Medical Centre 2] to [Medical Centre 1] without the EDI being changed on the [the radiology service] database. Contact details were amended and the report re-sent. [Medical Centre 2] would have received a copy of the report, but did not notify [the radiology service] that it should have gone elsewhere. [The radiology service] is reliant on GPs notifying them if their contact details have changed.

Comment: The referrer's contact details in this case were clearly listed on the referral, and were different to those on file. [The radiology service] has since changed its process of reviewing GP contact information to reduce the risk of results being sent to the wrong address. However, it was also a reasonable expectation from [the radiology service], on noting [Medical Centre 2] had received the report, that they would notify either [the radiology service] or [Dr E] that it had been received in error. [Medical Centre 2] maintain the result was viewed, printed off and posted to [Medical Centre 1] on 12 September 2011. [Medical Centre 1] maintain the result was not received, and it is not possible to verify from [Medical Centre 2] records precisely what action was taken regarding the result.

6. On 29 September 2011 [the public hospital] GP Liaison ([Dr H]) has written to [Mrs A] thanking her for notification by phone that *you have had your colonoscopy* [sic] *done privately and that you no longer require* [an] *appointment.* It is not entirely clear whether this call was made on the advice of [Medical Centre 1] staff (see section 4), or whether reference to cancelling the specialist appointment related to a different appointment.

7. On 2 November 2011 [Dr D] has assessed [Mrs A] and referred her to [the public hospital] with complaints of chest pain with exertion. In the letter he states *She was recently treated for anaemia…and had a colonoscopy two months ago to work up the anaemia in light of her history of colon cancer.* In brackets there is a handwritten note *Negative [initial]* — the initial I presume to be [Dr D's]. Blood tests were arranged. On 7 November 2011 [Dr D] is notified by [the public hospital] that [Mrs A] will be booked for an exercise ECG. This was undertaken on 21 November 2011 and was negative although there was poor exercise tolerance. Treatment as if for mild angina was advised. Blood results were reviewed by [Dr D] on 3 November 2011 and showed persistent anaemia (Hb 87 g/L) (although a small improvement from the result of 16 August 2011 (Hb 81 g/L)) and a mild thrombocytosis. [Dr D] has recorded a request to the nurses in relation to the result *repeat in 6/52, notified 9/11.* A further prescription for iron was supplied on 25 November 2011 ([Dr E]) as part of a nurse consultation to check blood pressure.

Comment: [Dr D] states he asked [Mrs A] about the result of her colonoscopy and was told by her it was normal. He was not told she had in fact had a CT colonography. [Dr D] states *Patients who have had a colonoscopy will receive results of the study the very same day, as will family members who accompany the patient. Therefore I had no reason to question the negative result given to me.* [Dr D] confirms his main concern on that day was [Mrs A's] worsening angina, and he arranged further investigation and management of this. His intention was to get this condition stabilised, and further treat [Mrs A's] anaemia, before she would be fit enough to undergo upper GI endoscopy which would be the next step in investigation of her anaemia. She was scheduled for repeat haemoglobin in six weeks, at which stage her usual provider would coordinate further investigation as indicated. [Dr D] finished his locum attachment two weeks after the consultation of 2 November 2011. Had [Mrs A's] colon investigation been negative (as was [Dr D's] belief), the management plan intended by him was not unreasonable. Upper GI endoscopy would certainly have been indicated in view of results suggesting ongoing blood loss, but it was reasonable to address the possible underlying angina as a priority to ensure [Mrs A] would be fit to undergo such a procedure. However, angina can be exacerbated by anaemia so it was appropriate to continue to treat this in the interim. It was probably reasonable for [Dr D] to assume [Mrs A] was correct when she conveyed her impression her investigations had been normal (there was no reason for him to believe she would intentionally mislead him), although investigating her response a little further might have led him to question the nature of her investigation (which he perceived to be colonoscopy) and therefore the absence of a result on file. Had the consultation been primarily to address ongoing symptoms directly referable to colon pathology, I would have been more critical of [Dr D] accepting only the patient's assertion that results were normal without formally checking the results himself.

8. On 19 December 2011 results from [Mrs A's] follow-up blood tests showed persistent anaemia (Hb 86 g/L) and provider [Dr F] has evidently asked a nurse to trace the colonography results as he was concerned about the persistent anaemia (see comments above). On 20 December 2011 the nurse has confirmed [Mrs A]

has been compliant with her iron replacement, and has telephoned [the radiology service] to get the results faxed. Later that day [Dr F] has recorded *CT colonogram result faxed in==* [Dr E] *going to contact pt and discuss with pt.* [Dr E] met with [Mrs A] and her daughters the following day and has recorded discussing the results, and apologising for the delay. Documentation includes *Notes in September about a CD coming in and never got here. Result was normal according to [Mrs A] but nobody notes to have given result. Apologised for delay and will find out where things went wrong, will get onto surgeon straight away and organise asap.* Nursing notes 22 December 2011 include *CT Colonography result sent to [Medical Centre 2] in September. I phoned and spoke to the Practice Manager today and she found the result in an inbox. Results are normally forwarded on but did not happen in this case.*

Comment: The actions of [Medical Centre 1] staff, on discovering the delayed result, appear to have been quite reasonable. The [Medical Centre 1] response indicates later information from [Medical Centre 2] differed to that given initially in that they claimed, in a letter to [Mrs A's] family, that the result had been posted to [Medical Centre 1] in September.

9. [Dr E] provided a written referral to surgeon [Dr I] on 21 December 2011 after speaking with him by phone. He notes the misunderstanding surrounding the colonography result including *the result was sent to me electronically but I never received it. After this she was seen by locum colleague and result was not discussed.*

[Mrs A] was seen by surgeon [Dr I] on 22 December 2011, who noted her to be remarkably asymptomatic of her cancer other than the anaemia. She was booked for urgent surgery and underwent wedge resection of the transverse colon cancer and small bowel resection on 12 January 2012. There was pericolic invasion and some lymphocytic infiltrate evident histologically, although it was not felt to be in [Mrs A's] best interests to consider adjuvant chemotherapy. At surgical follow-up on 5 April 2012 [Mrs A] was apparently well and awaiting colonoscopy for retrieval of the polyp noted on colonography.

Comment: Management of [Mrs A] from 21 December 2011 has been consistent with expected standards.

10. Concluding comments

(i) A major factor contributing to the delay in [Mrs A] receiving an accurate result of her colonography, and probably the most severe departure from expected standards if proven, remains unresolved — that being if, how and why she was given the impression by some [Medical Centre 1] staff member that her results were normal. This may have been a miscommunication (possibly referral to a result other than the colonography) or misperception (communication not intended to indicate the result was normal but perceived by [Mrs A] as such) or a frank error. I do not think further investigation is likely to clarify this situation further. Similarly, it is not possible to determine whether [Medical Centre 2] forwarded their copy of [Mrs A's] result to [Medical Centre 1] in a timely manner, or why

[Medical Centre 1] did not receive it if it was forwarded. These were two factors amongst many that contributed to the delay in receipt of the referral.

(ii) I have viewed a copy of the [Medical Centre 1] Test Results policy and this is robust and consistent with expected standards. It appears the policy was not followed 'to the letter' by [Dr D] or [Dr E] in that the patient Task Manager was not used to track return of a potentially very important result, and there was no formal handover of patients from the locum back to the regular GP on the locum's departure. The practice will ensure such actions occur in the future, and that locum staff are well acquainted with relevant practice policies, and these are appropriate actions taken in conjunction with those recommended in section 2 regarding the locum orientation process.

(iii) If [Mrs A's] assertion is correct that she contacted [Medical Centre 1] on several occasions to get the result of her colonography but was told to bring in her scan results in the first instance, this would be a mild to moderate departure from expected standards. I acknowledge the relevant facts are disputed in this case. The [Medical Centre 1] internal investigation determined that follow-up of the colonography result should not have been left up to the patient (to present the material received from [the radiology service]) but should have involved [Medical Centre 1] staff contacting [the radiology service] for a formal report, and I agree with this conclusion.

(iv) In terms of follow-up of results, as discussed in the body of this report I think there were departures from expected practice by both [Dr D] and [Dr E]. [Dr D] had ordered the colonoscopy and he had a duty to ensure this was done in a timely manner and the result followed up as appropriate. While a colonography had been undertaken rather than colonoscopy, and this was not ordered by him, he was under the impression a colonoscopy had been done and recorded a normal result (apparently based on verbal information from the patient, the patient stating such information had been given to her from practice staff) without formally checking the result. Under the circumstances (locum doctor, possibly suboptimal orientation, patient reassurance she had been told the result was normal, expectation the result would have been conveyed to family directly following the procedure (colonoscopy)) this is probably at most a mild to moderate departure from expected practice.

(v) [Dr E] ordered the colonography and therefore had a responsibility to ensure the result was received and followed up in an appropriate manner. His failure to use a 'back up' reminder such as Task Manager meant that the non-receipt of the result went undetected for several weeks. This was an important result as the patient was at high risk of malignancy as a cause of her symptoms having previously had bowel cancer. Complicating (perhaps mitigating) factors were that the patient was under the care of [Dr D] regarding investigation of her anaemia, and she was not enquiring after the colonography result once she had been reassured it was normal therefore removing one possible prompt for realising the result had, in fact, not been received. There was also a failure of another possible 'back-up' — that being non-receipt of the result apparently forwarded on from

[Medical Centre 2] when it had been received by them in error. A further 'back up' not used in this case might have been verbal notification of the significant abnormality detected by the radiologist to the referrer. However, had [Dr E] used a reminder system to ensure the result was received and actioned in a timely manner, it is likely the delay in receipt of the result would have been recognised far earlier. His failure to ensure the results of a test he had ordered were received and actioned in a timely manner was, under the circumstances, a mild to moderate departure from expected standards and he has indicated in his response he will be more vigilant with the use of this tool in the future.

(vi) It is not possible to say whether the three month delay in [Mrs A] receiving her surgery is likely to have altered her prognosis significantly. In some DHB areas, there is likely to have been this degree of delay if she was waiting for a public colonoscopy and surgery, without mishandling of results. While the failure to appropriately action a significantly abnormal result in a timely fashion must be regarded as a severe departure from expected standards, in this case there were multiple contributing factors individually representing less severe departures from expected standards and attributable to various providers, and the most significant and severe of which seem unlikely to be resolved. I think appropriate actions have been taken on the part of the providers involved including apologies to [Mrs A] for acknowledged factors leading to the delay. [Mrs A] should be reassured that her complaint has led to review of processes, and process improvements, by all named providers. I have no further comments or recommendations."