Management of gastroenterology referral
(13HDC00926, 26 June 2015)

General practitioner ~ Medical practice ~ Public hospital ~ District health board ~ Rectal bleeding ~ Gastroenterology referral ~ Grading ~ Follow-up ~ Information ~ Rights 4(1), 6(1)(c)

On 20 April 2012, a man in his fifties visited his general practitioner (GP) complaining of weight loss and going to the toilet as much as 40 times a day with rectal bleeding. The GP's differential diagnoses included irritable bowel syndrome and carcinoma. The GP instigated a referral to the local DHB gastroenterology department and requested blood investigations. Follow-up review was recorded "as needed". The GP did not give the man information about an expected timeframe for the specialist appointment, or what to do if he had not received an appointment time or if his symptoms worsened.

The 20 April referral was not received by the DHB and the GP did not use his Medtech patient information system to set a reminder to follow up the referral.

On 24 April, the man went to the Emergency Department (ED) at a public hospital with a painless right groin swelling. An ED specialist referred the man to the general surgical team for an inguinal hernia.

On 10 May, the DHB sent an electronic receipt message to the GP advising that the 24 April referral to the surgical team (the ED specialist's referral) had been declined. The GP (incorrectly) believed that this message related to his gastroenterology referral of 20 April.

On 2 July the man return to the medical practice with continuing bowel symptoms. He saw a locum GP who established that the initial 20 April referral had not been received by the DHB and so sent a further referral.

On 29 July, the DHB sent an electronic receipt message to the GP advising that the second referral to the gastroenterology department had been assigned a P2 priority — to be seen within six weeks. The waiting time for the appointment was deemed "unknown".

The DHB's standard referral waiting list acknowledgement letter to patients advised only that the referral had been graded by a specialist and had been accepted, and that the patient would receive an appointment "in due course". The letter also advised that patients should contact their GP if there was any change in their condition,

On 17 August, the man presented again to the medical practice, his symptoms were assessed. The decision was made to wait for the gastroenterology review. On 11 September 2012, the man presented to the public hospital ED with blood in his urine. The specialist reviewing him suspected rectal cancer, and transferred the man to another hospital. Tests revealed advanced metastatic carcinoma of the rectum. The man subsequently died.

The first GP was criticised for not classifying his initial referral as urgent, for not providing the man with a scheduled follow-up or advice on what to do if his symptoms persisted, and for failing to set an electronic reminder to follow up the referral. The GP also failed to identify that the decline message he received related to

a general surgical referral on a different date, he did not contact the man to check on his symptoms, and he did not advocate effectively for his patient by contacting the DHB to query its decline message. Accordingly, the GP did not provide services with reasonable care and skill and breached Right 4(1).

The processes in place at the medical practice at the time did not include a mandatory automatic reminder system, however, it was noted that the medical practice had since made changes to its DHB referral systems in line with current accepted standards.

The DHB's turnaround time and the delays in processing the GP's referral were substandard. In addition, the DHB did not provide the man with clear information about an estimated timeframe for a specialist assessment and so breached Right 6(1)(c).