General Practitioner, Dr B

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 10HDC00974)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. This report is about the care provided to a woman by her general practitioner (GP) in relation to the woman's bowel symptoms, over a period of nine months.

2. Mrs A, aged 62 years, consulted her GP, Dr B, at a medical centre in April 2009, complaining of rectal bleeding and discomfort. Dr B prescribed Mrs A Ultraproct[1] cream. Mrs A advised HDC that Dr B did not physically examine her. The documentation from this consultation is very limited, with no reference to the reason for the consultation, symptoms, clinical findings or diagnosis.

3. In July 2009, Mrs A returned to Dr B and requested that one of her regular medications (Losec) be changed to Solox.[2] Dr B also prescribed a repeat of the Ultraproct cream. Again the notes are very limited, with no reference to bowel symptoms or any other indication as to why Ultraproct had been prescribed, and instead of typing "Solox" (a proton pump inhibitor) in the clinical notes, Dr B typed "Solax" (an anti-depressant), although the correct medication (Solox) was prescribed. Mrs A advised HDC that Dr B did not physically examine her at this consultation.

4. On 30 December 2009, Mrs A consulted Dr B again. There is nothing documented in the clinical notes about the consultation, other than "see [referral] letter". This was a letter referring Mrs A to the Gastroenterology Department at the public hospital for a colonoscopy to "exclude pathology". Dr B noted in her referral letter that Mrs A had had diarrhoea for the past year and had lost five kilograms in the last four months.

5. Dr B forgot to print the referral letter and it was never sent.

6. On 9 February 2010, Mrs A went to the public hospital after experiencing severe bowel pain. She was initially treated for diverticulitis[3] with a small abscess. However, on 16 February 2010, after not responding to antibiotics, Mrs A had a computed tomography (CT) scan, which showed a four centimetre hole in her colon. She subsequently underwent a Hartmann's procedure,[4] which revealed a Stage II[5] cancerous tumour in her colon.

Decision summary

7. Dr B breached Right 4(1)[6] of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to examine Mrs A's abdomen and rectum on 20 April 2009 or on 27 July 2009. Dr B also breached Right 4(1) of the Code for failing to send the referral letter to the public hospital's Gastroenterology Department, and for failing to have in place an adequate system to alert her to instances where referrals had not

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[1] Ultraproct is a type of cortisone used to treat haemorrhoids, superficial anal fissures and proctitis.
[2] Both Losec and Solox are proton pump inhibitors, which are medications to reduce stomach acid.
[3] Small, bulging sacs or pouches of the inner lining of the intestine that become inflamed or infected.
[4] A surgical procedure where a section of the bowel is cut out and a colostomy is formed.
[5] This is also known as Duke's B Colon Carcinoma and means that the cancer has moved beyond the innermost layer of the colon and into the middle layer of the colon.
[6] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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been actioned as intended. Dr B also breached Right 4(2)[7] of the Code for failing to meet professional standards in terms of her documentation.

8. The medical centre did not breach the Code, but adverse comment has been made in relation to its systems for following up specialist referrals, and for repeatedly failing to inform Mrs A that her usual GP would not be present at booked appointments when those appointments had been booked with her usual GP.

Complaint and investigation

9. On 24 August 2010, HDC received a complaint from Mrs A about the services provided by Dr B and the medical centre. The following issues were identified for investigation:

- *The appropriateness of the care provided by Dr B to Mrs A from January 2009 to February 2010, including adequacy of documentation.*

- *The adequacy of care provided by the medical centre to Mrs A from January 2009 to February 2010, in particular the adequacy of its systems in relation to referrals and continuity of care.*

10. An investigation was commenced on 12 January 2011.

11. Information was reviewed from the following parties who were directly involved in the investigation:

Mrs A	Consumer/complainant
Dr B	General practitioner/provider
The medical centre	Provider

Also mentioned in this report:

Dr C	Respiratory consultant
Dr D	Locum doctor

12. Independent expert advice was obtained from general practitioner Dr Caroline Corkill and is attached as an appendix.

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[7] Right 4(2) states: “Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.”

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Information gathered during investigation

Background information

13. In 2009, Mrs A, aged 62, had several ongoing health problems including hypogammaglobulinaemia,[8] asthma, bronchiectasis,[9] sinusitis,[10] obesity,[11] and hypertension. She had been registered as a patient at the medical centre since August 2005, where her primary doctor was general practitioner Dr B.[12]

2009

14. Mrs A advised HDC that she consulted Dr B in April 2009[13] complaining of rectal bleeding and discomfort. Mrs A said that Dr B asked her if the blood she had noticed was fresh or dried, and she replied that she had seen red blood but did not know how to check for dried blood. Mrs A also advised that Dr B did not ask her any other questions about her symptoms, and did not carry out a rectal examination or examine her in any other way. Mrs A said that Dr B "did not lay her hands" on her, and that the consultation was "hurried". Dr B prescribed Mrs A Ultraproct cream for "possible haemorrhoids", although Mrs A did not have a history of haemorrhoids.

15. The first entry in Mrs A's clinical notes regarding her concerns about abdominal or bowel-related symptoms is on 20 April 2009,[14] when Dr B prescribed Ultraproct cream for Mrs A. Dr B's notes for this consultation record the following: "Imm: Flu Malignancy — G. Review of meds dsicussed ercare [sic]".

16. Dr B advised HDC that she accepts that her notes for the consultation on 20 April are "simply inadequate", but noted that while she did not wish to make excuses, Mrs A had "a number of complex medical problems that took some time to review with her". Dr B does not recall examining Mrs A, but advised HDC that "it is simply inconceivable" to her that she would not examine a patient complaining of any form of anal bleeding. Dr B advised HDC that the Ultraproct cream would have been prescribed for an irritated anus.

17. Dr B also did not recall what enquiries she made to determine the nature of Mrs A's rectal bleeding. However, Dr B advised HDC that her usual practice, when talking to a patient about haemorrhoids and to exclude sinister pathology, is to conduct an abdominal examination and ask patients if they have had any pains in the stomach, whether the blood was on the toilet paper or in the toilet bowl, and whether the blood looked red or black. Dr B said that if she was concerned about any of the answers, she would ordinarily arrange faecal occult bloods, and order a complete blood count. There is no evidence from the records that this occurred in Mrs A's case.

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[8] A disorder in which the body's immune system does not make antibodies, or makes a reduced amount of antibodies.
[9] A respiratory disease that causes the destruction of large airways.
[10] Inflammation of the sinuses.
[11] On 4 September 2008, Mrs A's weight is recorded as 111.7kgs.
[12] Dr B is vocationally trained as a general practitioner and is a member of the RNZCGP. She is a salaried director of the medical centre.
[13] Mrs A did not recall the date of the consultation, but it is recorded as being on 20 April 2009.
[14] This is aside from a consultation on 8 March 2006 where Mrs A complained of right-sided lower abdominal pain, which was followed up with a pelvic ultrasound.

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18. Dr B said that a medical student was present during this consultation and she "would not have missed an opportunity to teach the medical student about haemorrhoids and excluding sinister causes". Mrs A recalled another person being present, who she thought was a nursing student. Mrs A said that the student sat in the corner and did not say or do anything.

19. When contacted by HDC, the medical student was unable to recall this consultation.

24 April 2009–11 June 2009

20. Mrs A consulted two other doctors at the medical centre on 24 April 2009 and 5 May 2009. These consultations were in relation to a certificate for an invalid's benefit and a blood pressure check respectively. There is no mention of bowel or abdominal complaints or symptoms in the clinical record for either of these consultations.

21. On 11 June 2009, Mrs A consulted Dr B to follow up an Accident Compensation Corporation claim she had made in May 2009 in relation to a back injury. Dr B ordered an X-ray and noted "conservative care in the meantime". Mrs A said she did not discuss her bowel symptoms at this consultation.

16 June 2009

22. Mrs A was under the care of the district health board's (the DHB) Respiratory team for her bronchiectasis. On 16 June 2009, Mrs A attended the Respiratory Clinic at the public hospital for a routine review of her bronchiectasis, and was seen by respiratory consultant Dr C. Dr C sent Dr B a letter following the appointment to update her on the review findings. Dr C mentioned in her letter to Dr B that Mrs A did not have symptoms of malabsorption.[15]

27 July 2009

23. Mrs A consulted Dr B again on 27 July 2009. The records do not indicate the reason for the consultation. Mrs A stated that she informed Dr B that she had pain and persistent coughing. Dr B recorded the following notes: "doing well, to ctd [continue] with action plan though keen to trial solax, explained re potential side effects". Mrs A stated that the "action plan" was not discussed with her. Mrs A's weight was noted to be 99kgs.

24. Dr B prescribed Mrs A a number of medications at this consultation, including lansoprazole (Solox) and more Ultraproct cream.

25. Dr B said that, at this appointment, Mrs A said she was doing well, and that the reference to the "action plan" was the plan to treat Mrs A's back injury conservatively, as mentioned in the notes from the consultation on 11 June. Dr B also said that on review of her notes, she realised that she had mistakenly typed Solax instead of Solox, but she had prescribed the correct medication — Solox. Dr B advised that she is "sincerely endeavouring to be more accurate" with her documentation.

[15] Symptoms of malabsorption include: vomiting, nausea, bloating, chronic diarrhoea/loose stools, constipation, muscle wasting, weight loss, flatulence, and stomach pain.

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26. With regard to the repeat prescription for Ultraproct, Dr B said that she does not generate repeat prescriptions unless there is a valid reason, for example, if the patient reports a positive benefit and asks for a repeat, and she "can only suppose that the repeat of the prescription for Ultraproct was because Mrs A had reported some relief [of] her symptoms with the cream". She did not record this conversation. Dr B accepts that the quality of her documentation "let [her] down".

27. Mrs A said that at this consultation Dr B did not physically examine her. Mrs A said she felt that Dr B did not want to examine her. Mrs A also said that no other possible causes for her symptoms were discussed, and that Ultraproct was all that Dr B offered her. Mrs A stated: "I was looking for more help from my doctor."

28. Dr B said that she is "not sure whether [she] would have performed a further physical examination on 27 July 2009, particularly a rectal examination, if the patient was reporting that the Ultraproct had been effective".

20 October 2009

29. On 20 October 2009, Mrs A attended the Respiratory Clinic for a routine review, and was again seen by Dr C. In a letter to Dr B following the appointment, Dr C noted that Mrs A was concerned that the doxycycline[16] she had been prescribed may have been upsetting her bowels, causing increased flatulence and some intermittent problems with faecal incontinence. Dr C noted her advice to Mrs A that she should have a trial period of time off the doxycycline, and that Mrs A was going to try switching to another antibiotic in the long term.

24 November 2009

30. Mrs A said that she made an appointment to see Dr B on 24 November 2009, but she was seen by Dr D (a locum doctor at the medical centre). The notes from this consultation record Mrs A's complaints of ongoing cough and right-sided sternal pain. The notes also record a history of "Loose bowels" for more than one year, and that there was "Giardia in [the] district". Dr D noted that, on examination, Mrs A had costochondritis.[17] Dr D ordered stool bacterial cultures and prescribed Mrs A a number of medications, including Ultraproct.

31. Mrs A advised HDC that Dr D did not examine her rectum or bowel area, although he did examine her chest in relation to her chest pain. She stated: "This was yet another opportunity lost to locate the real reasons for my problems that went untreated." She attributes this to "yet another GP handling [her] consults".

32. Dr D advised HDC that as it was 21 months since he had seen Mrs A, he was unable to recall the consultation. From reviewing the consultation notes, Dr D believes that Mrs A requested Ultraproct as a repeat medication. However, he is unable to recall what symptoms caused her to request a repeat, and the reason is not recorded.

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[16] An antibiotic used to treat bacterial infections. Mrs A had been prescribed doxycycline on an ongoing basis since May 2007 at the recommendation of her Respiratory Physician.

[17] Inflammation of the junction where the upper ribs join with the cartilage that holds them to the breastbone or the sternum.

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33. Dr D is also unable to recall the details of any discussion he may have had with Mrs A about her diarrhoea symptoms, but as he understood from Mrs A that there was Giardia present in the community, he felt that initial investigation of the diarrhoea should be a microscopy and culture of the faeces. Dr D further advised HDC that the subsequent follow-up would depend on the results from that testing, and his usual practice would be to advise the patient to discuss the results with his or her usual GP.

34. On 27 November 2009, the results from Mrs A's stool cultures were reported with no abnormalities detected for infection or parasites.

23 December 2009

35. On 23 December 2009, a nurse from the medical centre contacted Mrs A to advise her of the results from her stool cultures. Mrs A advised the nurse that she was continuing to have loose bowel motions, and an appointment was made to see Dr B on 30 December 2009.

30 December 2009

36. Dr B saw Mrs A on 30 December 2009. Mrs A said she told Dr B: "I cannot go about my normal living due to this diarrhoea happening every three hours." Mrs A advised HDC that at this appointment Dr B examined her abdomen and said three times: "I'm very sorry we have missed something. I'll do everything I can." Mrs A said that Dr B asked whether there was bowel cancer in her family, and Mrs A replied that there was not. Mrs A said that Dr B definitely did not examine her rectum. Dr B cannot recall whether she examined Mrs A's rectum. However, she advised HDC that as part of her standard examination where she is requesting a colonoscopy, she would perform a rectal examination, and her reference to "all systems nad [no abnormality detected]" is her note to that effect.

37. Dr B prescribed tablets for Mrs A's diarrhoea and told Mrs A that she would arrange a colonoscopy for her at the public hospital. Mrs A recalls that Dr B told her that she would be put on a waiting list for a colonoscopy and would be contacted by the hospital in about three to four months for an appointment. Mrs A said she was not given a copy of the referral letter, and Dr B did not tell her she should contact the public hospital if she did not hear from the hospital about her referral.

38. The clinical notes for the consultation on 30 December 2009 simply read: "see ref letter". Dr B ordered blood tests[18] and recorded Mrs A's weight, which was 93.4kg.

39. The referral letter Dr B mentioned in Mrs A's notes was a letter dated 30 December 2009, referring Mrs A to the Gastroenterology Department at the public hospital for a colonoscopy to "exclude pathology". Dr B noted in her referral letter that Mrs A had had diarrhoea for the past year and had lost 5kg in the last four months. Dr B also advised in her letter that no blood had been noted but Mrs A had "known piles",[19] and

[18] The blood tests were albumin/creatinine ratio, complete blood count, glucose/glycated proteins, renal function, liver function, thyroid function, lipid tests, immunoglobulins, and coeliac antibodies.

[19] This is the first reference to Mrs A's "piles" or haemorrhoids anywhere in Mrs A's clinical record. Mrs A told HDC that she has never had haemorrhoids.

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that "[o]n examination [abdomen] soft, LSKK NP,[20] bowel sounds nad [no abnormality detected]. All systems nad [no abnormality detected]".

40. Dr B said that while she cannot remember the exact content of the conversation she had with Mrs A, it is her nature to be very supportive and open and honest. She therefore believes that it is "quite likely" she would have said to Mrs A something along the lines of "I'm sorry if we have missed something. If we have I'll do everything I can to help."

41. Dr B advised HDC that "it is standard practice policy" to tell patients who are waiting for appointments to check with the hospital if they have not heard from them within two to four weeks, and she believes she "definitely would have" advised Mrs A to follow up with the hospital or the practice if she had not been contacted within two weeks. The medical centre advised HDC that there is no written policy, and reminding patients to follow up on test results "is something we 'just do'". Mrs A said that this advice was not given to her.

42. Dr B forgot to print and send the referral letter. At the time of generating the referral letter, Dr B could have entered an alert on her computer which would have reminded her, by way of a pop-up on her computer screen, to follow up Mrs A's referral if she had not heard back from the public hospital within a nominated time frame. However, Dr B did not do so. Accordingly, no colonoscopy appointment was arranged for Mrs A as the public hospital was not aware of the referral, and Dr B did not realise she had not sent it. It was not until Dr B was notified of Mrs A's complaint to HDC in September 2010 that she realised she had failed to send Mrs A's referral letter.

9 February 2010

43. Mrs A says that on 9 February 2010 she was "thrown" from her chair by what felt like "an explosion" in her bowels. She was in pain and vomiting, so her daughter drove her to the public hospital.

44. An X-ray of Mrs A's abdomen was carried out, and initially she was treated for diverticulitis with a small abscess. However, she did not respond to antibiotics so, on 16 February 2010, Mrs A had a CT scan. This showed a four centimetre hole in her colon. On 17 February 2010, Mrs A underwent a Hartmann's procedure. During the procedure Mrs A was found to have a tumour, which had caused a bowel obstruction and the subsequent perforation to the bowel.

45. In a letter from the medical oncologist to the general surgeon who operated on Mrs A, dated 15 March 2010, the medical oncologist noted that Mrs A had advanced cancer but it had not spread to the local nodes (known as Stage II or Duke's B carcinoma), and her prognosis was good.

46. On 6 May 2010, Mrs A transferred her primary care to another medical practice.

[20] Dr B advised HDC that this refers to an examination of liver, spleen, kidney, kidney not palpable.

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Weight loss

47. In September 2008, Mrs A weighed 111.7kgs. This had dropped to 99kgs on 27 July 2009 and to 93.4kgs on 30 December 2009. There are occasional references in her clinical notes to the fact that Mrs A was being encouraged to lose weight. For instance, in a letter dated 7 June 2006 from a DHB respiratory physician to Dr B, he notes that Mrs A had just bought a treadmill and was very keen to use it. He adds towards the end of his letter that Mrs A "certainly must increase her exercise and must lose weight".

48. Similarly, in a letter dated 13 May 2008 from the respiratory physician to Dr B, the respiratory physician recommends that Mrs A "continue with her weight reduction programme and increased exercise programme in order to improve her fitness/aerobic capacity and facilitate chest clearance".

49. On 27 May 2008, a provider at the medical centre (not Dr B) has documented that Mrs A called for her results, and that "[lipids] a little raised and have discussed exercise and low fat diet …"

50. On 16 January 2009, yet another provider at the medical centre has documented Mrs A's weight (104.5 kg) and noted "encourage ongoing [weight] loss".

51. Mrs A advised HDC that while she was aware that she was losing weight, she was not actively trying to do so. She further advised that Dr B did not mention her weight loss at any of the consultations, and Mrs A did not bring it up.

52. Dr B has acknowledged that Mrs A's weight loss was a "red flag", but added that Mrs A had always been encouraged to lose weight and that since September 2008 she had been steadily doing so. Dr B has noted that in hindsight it is easy to attribute Mrs A's weight loss to the subsequent cancer diagnosis, but that at the time, it seemed consistent with her efforts to lose weight, and her diarrhoea. However, Dr B did not record in Mrs A's records that she had complained about having diarrhoea. The only record of this is on 24 November 2009, when Mrs A was seen by Dr D. Dr C's reporting letter to Dr B following the 20 October 2009 consultation noted that Mrs A was concerned that the doxycycline she had been prescribed may have been upsetting her bowels, causing increased flatulence and some intermittent problems with faecal incontinence.

Reminder system

53. At the time of these events, the medical centre did not have an automatic reminder system in place to ensure referrals were followed up, preferring to leave it up to the individual doctor to manually set up a reminder on a case-by-case basis.

54. A Cornerstone Assessment Report dated 4 February 2009, which was produced following an audit of the medical centre in November 2008, identified the lack of any prompt or reminder system in place at the medical centre to alert its doctors to referrals that have not progressed as intended, and the risk it faced if an adequate system was not implemented:

"**Gaps/ Areas for improvement**:

HDC

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The system would be improved by developing a more thorough autotasking system. Currently the smear request form is autotasked but not so other referrals.

Recommendations:
It is recommended that the team [determine] which lab tests and which referrals they wish to automatically task so that failed referrals or failure of a test to generate an inbox result will be picked up in the task reminder of the GP ordering the test or referral.

Note that the recent NZ Doctor again emphasised this (November 5) in the HDC's (Ron Paterson) column. Given the ability of Medtech to provide this back up, there would be no legitimate excuse for failure should an incident occur.

…

Similarly, it is recommended that all radiology and all specialist referral letters be auto tasked."

55. The medical centre provided Cornerstone with the following response:

"It was decided that Histology and FNA [fine needle aspiration] requests be set up with an auto task but that other results be manually auto tasked on a case by case basis by the provider requesting the test. Auto tasks for referral letters were also discussed. Since we are currently using a generic outbox referral letter it was decided that auto tasks for these should also be set manually by the referring provider on a case by case basis. All doctors and nurses have been shown how to do this."[21]

56. The Cornerstone "Lead Assessor" responded:

"This is a good response: I recommend you keep under review the range of autotasks — you might feel more secure autotasking your specialist and hospital referrals as well. But I realise there may not have been consensus and you have to start somewhere!"

57. In April 2011, Dr B advised HDC that the medical centre had introduced an Electronic Referral Management System (ERMS) for all referrals to public hospitals. This eliminates the need to send referrals by fax, as they are sent electronically by the doctor or "parked", and the administration team can then check to ensure that there are no outstanding "parked" documents at the end of each day.

58. Dr B advised that the ERMS is currently unavailable for referrals to private specialists. In the case of private referrals they continue to use the old system of printing and faxing the referral but have introduced a reminder system for all outbox

[21] The medical centre explained to HDC that it uses the generic outbox referral letter template for things that require follow-up, as well as for things that do not require follow-up (eg, letters on behalf of a patient to Work and Income New Zealand). Accordingly, the doctors chose to set auto-tasks on a "case by case basis" as they did not want to overload their inboxes with items that did not require follow-up.

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documents so that whenever a referral letter is generated the doctor will automatically receive a prompt three weeks later asking if a response has been received from the specialist.

Documentation policy

59. The medical centre does not have a policy setting out expectations or standards required in terms of documentation by its staff.

60. However, the medical centre advised HDC that it achieved Cornerstone accreditation in October 2005 and re-accreditation in 2008. As part of this process, all practice GPs undergo two medical record audits and each GP reviews his or her own notes and makes action plans based on the findings, which are then reviewed by an RNZCGP assessor. While some issues with quality of the notes were noted (namely the failure to consistently record information about family history and alcohol/drug history) during the re-accreditation process in November 2008, the Cornerstone assessor passed the items as met, because the doctors had already identified the issues and produced an action plan in response. Dr B advised HDC that apart from the findings of this audit, no other issues or concerns have been raised regarding the quality of her clinical notes.

61. The medical centre further advised that in April 2010 it underwent a quality review by Health and Disability Auditing New Zealand Ltd[22] which included a review of GP notes, and no issues were identified.

Apology and changes to practice

62. Dr B and the medical centre advised HDC that they were "very distressed and upset to learn of [Mrs A's] circumstances and her feelings about the services we provided. We offer our most profound apologies for any part that we have played in the treatment outcome of her disease or her distress during what we understand is a very difficult time." On 10 May 2012, HDC received a written apology from Dr B, for forwarding to Mrs A.

63. Dr B advised HDC that since Mrs A's complaint she has made a series of changes to her practice. For instance, Dr B said that when a patient presents with anal, rectal, abdominal, or bowel symptoms, or complains of other gastro-intestinal related symptoms she will always perform a full examination and order appropriate tests to exclude other pathology and to ensure her diagnosis is correct. She said she will also document the full history and examination findings, and if in doubt, seek a second opinion and refer the patient to an appropriate consultant.

64. Dr B also advised that she is undertaking a full audit of all patients who have been prescribed Ultraproct or Proctosedyl[23] medication in the last 18 months, and will review her notes for documentation of examinations and follow-up.

[22] Health and Disability Auditing New Zealand Ltd provides auditing services to providers of health and disability services.
[23] Proctosedyl is an ointment used for the relief of discomfort caused by haemorrhoids.

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65. Dr B said she is also ensuring all patient documentation is completed in accordance with the RNZCGP Cornerstone guidelines. She advised HDC that the two directors of the medical centre (including herself) have designed an annual internal medical record review of all doctors' notes (this will be in addition to the three-yearly Cornerstone audit). Dr B advised HDC that after completing the internal documentation audit, feedback will be provided to the individual employee and any necessary action will be taken to ensure the RNZCGP Cornerstone guidelines for documentation are complied with. Dr B also advised that her notes will be audited every six months until such time as she feels she is consistently meeting and exceeding RNZCGP Guidelines for documentation.

66. Dr B also advised HDC that the medical centre has employed an additional staff member to ensure that the robustness of the internal systems and processes at the practice are maintained at all times, and has introduced a protocol to ensure that where a provider is on leave, his or her patients' test results and correspondence automatically go to another provider to review and follow up.

67. Dr B advised HDC that "the team at [the medical centre] strive to deliver patient-focused care and as such encourage all patients to be involved in their health care plans and treatment. We advise patients to notify their GP if they have not received an appointment or follow-up by the agreed date." Dr B further advised HDC that she will endeavour to explain to her patients the reasons for having tests done and how important it is for them to be involved in, and part of, their own care.

Appointments and continuity of care

68. Mrs A advised HDC that she often made appointments to see Dr B but on arrival she was told that Dr B was away and that she would be seen by another doctor.

69. The medical centre's practice coordinator advised HDC that Dr B has been making trips overseas to provide medical aid since 2007, and they are mindful of the disruption this can cause to continuity of care. The practice coordinator advised HDC that they support those patients affected by Dr B's absences by having four other general practitioners[24] and one locum available to provide care.

70. Dr B advised HDC that their patients are always advised to return if their symptoms persist, and it is their practice for the doctors to review the previous two consultations, as well as check the recall list, and any alerts on the patient file, and to check with the patient if there is anything that needs following up.

71. The practice coordinator advised HDC that if at any time Mrs A was led to believe that she would be seeing Dr B, only to learn on arrival that she was booked with a different doctor, they extended their "most sincere apologies" for this.

72. Following the receipt of Mrs A's complaint, the medical centre introduced a new policy, "GP on Leave or Working Offsite". This policy outlines the processes to be followed, and the information to be given to patients when a doctor at the practice is on leave and when Dr B is working offsite. The policy states that if a patient requests

[24] Only two of the five doctors listed on the medical centre's website are vocationally registered as GPs.

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an appointment with a doctor at the practice who is on leave, the receptionist will inform the patient that the doctor is on leave and offer the patient an appointment with the doctor on his/her return from leave. The patient will also be offered the option of taking the next available appointment with another doctor at the practice.

73. The practice coordinator advised HDC that receipt of Mrs A's letter has highlighted how important clear communication is, and they will address this as a team "to ensure that in the future patients are left in no doubt about when [Dr B] is overseas and when she is not".

Standards

Clinical care

74. The applicable standards in relation to the provision of clinical care are set out by the Medical Council of New Zealand in the document "Good medical practice".[25] According to this guide, good clinical care includes:

- adequately assessing the patient's condition, taking into account the patient's history and his or her views and examining the patient as appropriate
- providing or arranging investigations or treatment when needed
- taking suitable and prompt action when needed
- referring the patient to another practitioner when this is in the patient's best interest.

Records

75. The requirement for doctors to keep clear and accurate clinical records is set out in the Medical Council of New Zealand's document "The maintenance and retention of patient records".[26] This states that doctors "must keep clear and accurate records that report relevant clinical findings, decisions made, information given to patients, any drugs or other treatment prescribed".

Opinion: Breach — Dr B

Physical examinations

76. My clinical expert advisor, general practitioner Dr Caroline Corkill, advised that, given the high incidence of bowel cancer in New Zealand, especially in people aged over 50 years, she would expect Dr B to have recorded some information about Mrs A's bowels at one of the consultations where she prescribed Ultraproct cream. Dr Corkill added that "it is not safe to assume rectal problems are always from haemorrhoids even in someone with a known history of this problem", and that a

[25] Ian St George (ed), "Good medical practice: a guide for doctors", *Cole's Medical Practice in New Zealand* (2009), at pg 9. Available from http://www.mcnz.org.
[26] http://www.mcnz.org

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basic examination should have included a palpation of Mrs A's abdomen and a visual inspection of the anus with a digital rectal examination. Possible other investigations would be to check Mrs A's iron levels and conduct a faecal occult blood test if there was no obvious rectal bleeding, and consider referring her for a colonoscopy.

77. Dr B saw Mrs A on four occasions in 2009. These consultations were on 20 April, 11 June, 27 July, and 30 December. At two of these consultations (20 April and 27 July) Dr B prescribed Mrs A Ultraproct cream, but the clinical notes do not mention any bowel or abdominal symptoms or physical examination.

78. Mrs A is adamant that Dr B did not carry out any physical examination at the consultations on 20 April 2009 and 27 July 2009. Dr B does not recall carrying out examinations at either consultation, but believes she would have done so.

79. Dr B's documentation does not provide any assistance as to what may have taken place at these consultations. At the consultation on 20 April there is an implication that something was said about Mrs A's bowels or bowel habit because Ultraproct was prescribed, but there is no record of the reason for the consultation, the history provided by Mrs A, the signs seen on examination, nor the plan to deal with the problem or problems.

80. Similarly, on 27 July, Dr B prescribed Mrs A a repeat prescription of Ultraproct, but there is no record of bowel symptoms, examination findings, or a plan to manage or treat the problem. I note Dr B's advice that she would not have provided a repeat prescription of Ultraproct unless the patient had reported it had been effective. If so, this information should have been documented.

81. Such poor documentation makes it difficult to definitely ascertain what occurred at these consultations, and whether Dr B adequately assessed and examined Mrs A's condition in accordance with the Medical Council's guidelines. As noted by the High Court, it is through the medical record that doctors have the power to produce definitive proof of a particular matter. Doctors whose evidence is based solely on their subsequent recollections (in the absence of written medical records offering definitive proof) may find their evidence discounted.[27]

82. I agree with Dr Corkill's advice that if Dr B had not examined Mrs A at the consultation on 20 April, then this should have been done at the consultation on 27 July, and her findings should have been documented. In my view, it is unlikely a patient would forget something as invasive as a rectal examination. Dr B does not recall carrying out physical examinations and has not documented doing so. She has relied on what she believes she *would* have done. In the absence of clinical records to the contrary, I consider it more likely than not that Dr B did not physically examine Mrs A on either occasion.

30 December 2009 — Colonoscopy referral

83. At the consultation on 30 December, Dr B wrote a letter referring Mrs A for a colonoscopy. However, Dr B forgot to print and send it. Dr B had no system in place

[27] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-406-14, 15 March 2005).

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to alert her to the fact that the referral had not been sent, and she was not aware that the referral had not been sent until nine months later when she received a copy of Mrs A's complaint about her.

84. Medical providers need to have robust systems in place to ensure mistakes and omissions are identified at an early stage to prevent harm being caused to the patient. 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. Dr B did not do this, despite the fact that this automatic reminder system was a function available to her.

85. Another precaution providers can take is to ask the patient to contact the clinician to whom they have been referred, directly, if they have not heard from them within a certain time frame. A provider who explains to the patient the purpose of the referral and its importance not only ensures that the patient is adequately informed, but also encourages the patient to be vigilant in following up if the referral appointment is not received. Dr B believes she "definitely would have" advised Mrs A to contact the public hospital or the medical practice if she had not heard from the hospital about her appointment within two weeks. However, Mrs A stated that Dr B did not provide this advice, and there is nothing in the records to suggest otherwise.

86. Dr B's failure to send the referral letter to the public hospital, combined with her failure to put in place any precautionary measures to ensure that she would be alerted if the referral was not actioned, was an inadequate standard of care. Dr B's omissions meant that Mrs A was not given the opportunity to have her symptoms investigated by a specialist in a timely manner, which may have resulted in an earlier diagnosis of her cancer.

Conclusion

87. In my view, Dr B failed to provide services to Mrs A with reasonable care and skill. Dr B did not physically examine Mrs A on 20 April and 27 July, and prescribed further Ultraproct to her without having examined her at either consultation. In addition, Dr B did not send the referral letter and failed to use the automatic reminder system. Accordingly, Dr B failed to provide Mrs A with services with reasonable care and skill and breached Right 4(1) of the Code.

Documentation

88. Doctors are required to keep clear and accurate records that report relevant clinical findings, decisions made, information given to patients, and any drugs or other treatment prescribed.

89. Dr B's notes in relation to Mrs A's consultation on 20 April 2009 simply state: "Imm: Flu Malignancy — G. Review of meds dsicussed ercare [sic]". This was followed by a list of medications she had prescribed Mrs A, including Ultraproct cream.

90. The record does not provide any information about the reason for the consultation, or what took place during the consultation, such as what was observed by Dr B, and what was diagnosed. Similarly, at the consultation on 27 July, Dr B repeated the

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prescription of Ultraproct cream without documenting anything to indicate why this was prescribed. Dr Corkill has advised HDC that she would expect Dr B to have recorded some information about Mrs A's bowels at one of the consultations at which Ultraproct cream was prescribed.

91. Dr Corkill has also noted other concerns with Dr B's notes from 27 July. For instance, Dr B makes reference to an "action plan" but it is not clear what this is about, and when changing Mrs A's medication to Solox she mistakenly typed Solax in the clinical notes, although she wrote the prescription for Solox.

92. A detailed and clear record of the patient's history, assessment and management plan is one of the cornerstones of good care, and is particularly important for continuity of care at practices like the medical centre, where a patient is likely to receive care from more than one doctor. As noted in a previous opinion involving a medical centre similar in structure to this medical centre:[28]

> "… [I]t is vital that a detailed and clear record of the history, examination, assessment and management plan of each consultation is documented, in order to assist other doctors at the Centre to provide continuity of care to the patient."

93. This is supported by Dr Corkill, who advised that in practices where patients are regularly seen by different doctors, "it is crucial to record [examination findings] for the benefit of the other doctors who may need to follow up on a problem".

94. I agree with Dr Corkill. In light of Dr B's frequent absences from the practice it was particularly important that her notes were sufficient to ensure continuity of care. The notes should have been more structured and contained more detail, clearly stating Mrs A's history, any examination findings, and the treatment plan. In my view, it was unsatisfactory for Dr B to fail to document anything in Mrs A's record about the reason for prescribing Ultraproct cream, including any reported symptoms. Dr B's notes on 27 July were unclear and inaccurate, which further jeopardised coordination of Mrs A's care in Dr B's absence. Accordingly, Dr B's documentation did not comply with professional standards and, as a result, she breached Right 4(2) of the Code.

95. Dr B has taken steps to improve her documentation, including carrying out an annual audit to ensure all patient documentation is completed in accordance with the RNZCGP Cornerstone guidelines. In addition to this, she will have her documentation audited every six months until such time as she feels she is consistently meeting and exceeding RNZCGP Guidelines for documentation.[29]

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[28] Opinion 08HDC06359. See also Opinion 03HDC03134 and Opinion 06HDC12164.

[29] Dr Corkill has noted that the RNZCGP Cornerstone guidelines for documentation are very comprehensive, and considers a more reasonable approach would be to use the Cornerstone guidelines to audit the notes and see where and how they can continue with improvements in the quality of their documentation.

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Opinion: Adverse comment — Dr B

Weight loss

96. On 30 December 2009, Mrs A weighed 93.4kgs. This was 18.3kgs less than she had weighed 15 months previously. Mrs A has advised HDC that she was not actively trying to lose weight, and her weight loss was never mentioned by, or discussed with, Dr B.

97. Dr B has acknowledged that Mrs A's weight loss was a "red flag" but added that Mrs A had always been encouraged to lose weight. Dr B has noted that in hindsight that it is easy to attribute Mrs A's weight loss to the subsequent cancer diagnosis, but at the time it seemed consistent with her efforts to lose weight, and her diarrhoea.

98. I note that there were references in Mrs A's clinical notes to her weight, and that she was being encouraged to lose weight. However, these were notes made by other providers, not Dr B.

99. Dr Corkill has advised that the loss of 18kgs over a 15-month period is "significant" and in retrospect it should have been regarded as a red flag for consideration of a sinister diagnosis such as bowel cancer. Dr Corkill considers Dr B's failure to note the significance of Mrs A's weight loss to be a departure from expected standards. However, Dr Corkill accepts that there were factors that mitigated the severity of her omission. For instance, Mrs A was being encouraged to lose weight by other doctors she was seeing, and the weight loss was steady, which would make it harder to determine at what point it became significant. In view of these factors, Dr Corkill considers that Dr B's peers would regard this aspect of care as an "understandable oversight in the circumstances, and therefore of a minor degree".

100. I agree with Dr Corkill that Dr B's failure to note the significance of Mrs A's weight loss needs to be considered in view of the fact that Mrs A was being encouraged to lose weight and that the weight loss was steady over a 15-month period. Accordingly, I do not consider Dr B breached the Code in this respect.

Opinion: Adverse comment — The medical centre

Appointments

101. This Office has stated:[30]

> "All medical centres have a responsibility to ensure that quality of care is not compromised for patients with chronic problems … It is a reminder of the benefits for patients in having an ongoing relationship in primary care with a medical practitioner who is familiar with them and their medical history."

[30] Opinion 08HDC06359.

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102. Mrs A advised HDC that when she made appointments to see Dr B she was frequently told when she arrived that Dr B was away and that she would be seen by another doctor. These were not emergency or walk-in appointments. The records indicate that Mrs A was seen by a number of clinicians, and I accept her statement that she was not advised in advance that Dr B would not be available to see her.

103. The medical centre has apologised if this was the case, and advised HDC that Mrs A's letter has highlighted to them how important clear communication is, and that they have addressed this as a team "to ensure that in the future patients are left in no doubt about when [Dr B] is overseas and when she is not".

104. It is understandable that Mrs A wished, as far as possible, to have continuity of care with the same GP, particularly as she had a number of co-morbidities. It is clear that she was seen by a number of clinicians at the medical centre. Mrs A had the right to express a preference as to which doctor she would see, and should have been told if it was not possible to meet that preference.

105. In order for Mrs A to make a choice whether to accept the appointment offered, she needed to know whether her usual GP would be present. This is information that a reasonable patient would expect to receive.

106. The medical centre has implemented a new policy which clearly outlines the processes to be followed when a doctor is on leave, including what information should be given to patients. In my view, the medical centre should reflect on its obligations in this regard and ensure that all staff are aware of and implement the new policy.

Process for following up referrals

107. At the time of these events, the medical centre did not have a system in place to follow up referrals to specialists, preferring to leave it up to the individual doctor to make his or her own arrangements on a case-by-case basis.

108. I note that the risk of not having an automatic reminder system in place for specialist referrals had been specifically raised with the medical centre following the Cornerstone audit in November 2008, where it was noted that while automatic reminders were being used for smear tests and recalls, they were not being used for other tests and referral letters. Cornerstone recommended to the medical centre that radiology and all specialist referral letters be "auto tasked" (have automatic task bar reminders), noting that, "Given the ability of Medtech to provide this back up [automatic task bar reminders] there would be no legitimate excuse for failure should an incident occur."

109. Despite this warning, the medical centre made a deliberate decision not to implement an automatic task bar reminder for specialist referrals, because it did not want the doctors' inboxes to become overloaded with reminders that did not require follow-up. Accordingly, the medical centre decided its doctors would continue with the practice of placing reminders on their computers on a "case by case basis", despite the potential risk to patients should a doctor forget to insert such a reminder.

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110. When the medical centre advised Cornerstone that it had decided to set up auto task reminders for histology and fine needle aspiration but not for other results or referral letters, the Lead Cornerstone Assessor responded:

> "This is a good response: I recommend you keep under review the range of autotasks — you might feel more secure autotasking your specialist and hospital referrals as well. But I realise there may not have been consensus and you have to start somewhere!"

111. Had the medical centre required its doctors to use the automatic reminder system for its referral letters, Dr B should have been alerted to the fact that Mrs A's colonoscopy referral was not being actioned. It is likely that this would have led to the realisation that the letter had never been sent, and the appropriate remedial action could then have been taken in a timely manner.

112. I consider that the establishment of an effective alert system is a reasonable precautionary action for a medical practice to take to ensure referrals are not lost or forgotten. It was only once an error had been made, and a patient put at risk, that the directors of the medical centre decided to take the precautionary step of implementing an automatic alert system for following up referrals. The medical centre had been warned by the Cornerstone assessor about the risks of not having automatic task bar reminders for referrals to specialists, even to the point of being advised that it would have "no legitimate excuse" should an incident occur involving failure to follow up a referral letter or test results. However, the assessor indicated guarded support when the practice decided not to auto-task radiology and specialist referral letters.

113. In my view, the decision not to implement a mandatory automatic alert system for following up specialist referrals, on the grounds that the doctors' inboxes may become overloaded with reminders that did not require follow up, was unwise. The existing system relied upon doctors entering automatic alerts to appear on their computer screen on a case-by-case basis.

114. While I accept that the medical centre may have felt some reassurance that its systems were adequate when it passed the Cornerstone accreditation audit, I note that the Cornerstone Assessor did warn the medical centre of the risk it was taking by not implementing a more robust reminder system.

115. In my view, more care should have been taken by the medical centre to put in place a reminder system for following up specialist referrals, which would not be subject to individual error. The medical centre should reflect on the contribution of its poor systems to the unsatisfactory care provided to Mrs A.

Recommendations

116. In response to this case, Dr B and the medical centre have taken steps to improve those aspects of their service that have been identified as suboptimal, namely

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documentation, processes for following up referrals, and continuity of care. These are commendable steps. However, I consider that the following further steps should be taken:

- The medical centre 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 **31 August 2012.**

- Dr B to enter into a mentoring relationship with a general practitioner appointed by the Royal New Zealand College of General Practitioners (RNZCGP) (including at least three face-to-face meetings with the mentor each year) until **31 December 2013.** The mentor should focus on those areas of Dr B's practice that were identified in this report as substandard or needing attention. The mentor should provide written confirmation to RNZCGP and HDC that the mentoring has occurred, and his/her evaluation of Dr B's practice in the identified areas of concern.

Follow-up actions

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

- 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.

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Appendix — Independent expert general practitioner advice

The following expert advice was obtained from general practitioner Dr Caroline Corkill:

> "Thank you for asking me to provide expert advice in this case, number 10/00974. I am a General Practitioner, a Fellow of the Royal New Zealand College of General Practitioners, working in Invercargill. I have given advice to the Commissioner on a number of cases in the past.
>
> Information provided to me I have read, includes:
>
> 1. Complaint (pages 1–10)
> 2. File note of conversation between [investigator] (office of H&DC) and [Mrs A] (pages 11–12)
> 3. [The medical centre's] response to complaint (including clinical records) (pages 13–178)
> 4. Notification letters to [Dr B] and [the medical centre] (pages 179–188)
> 5. Information from [Dr B] dated 24 March (page 193–206)
> 6. Information from [the medical centre], dated 21 April (pages 207–240)
> 7. Clinical records from [current GP] (pages 241–306)
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I refer to "Cole's Medical Practice in New Zealand 2011": Edited by Ian St George, for current standards of medical care applicable in this case.

[At this point in her advice Dr Corkill sets out the background facts. This detail has been omitted for the purpose of brevity.]

> **Expert Advice**
> *[Dr B]*
>
> Answers to your questions:
>
> 1. The **standards which apply in this** case are the standards of 'Good clinical care' as set out by the Medical Council of New Zealand in the document 'Good medical practice', Chapter 1 of Cole's Medical practice in New Zealand 2011.
>
>   Under this guide (page 10) the Medical Council states 'Good clinical care includes:
>
>   - adequately assessing the patient's condition, taking account of the patient's history and his or her views and examining the patient as appropriate
>   - providing or arranging investigations or treatment when needed

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- taking suitable and prompt action when needed
- referring the patient to another practitioner when this is in the patient's best interest'

On page 199 of this book is a summary of The Code of Rights of the Health and Disability Commissioner which says '4. Consumers should be treated with reasonable care and skill and receive well coordinated services.'

2. In my opinion there was a departure from those standards by [Dr B].

   Discussion:
   [Dr B] saw [Mrs A] four times during 2009. These consultations were on the 20th April, the 11th June, the 27th July and the 30th December.

   The notes recorded by [Dr B] at all of these visits are poor. This does not necessarily mean the consultation itself was poor as there are a lot of things happening in a consultation. Written records may not reflect accurately what has happened in the listening, examining, diagnosing and explaining process. The notes from this doctor in this case are consistently unsatisfactory in that they do not record the reason for the consultations, the symptoms noted by the patient, the signs seen on examination, nor the plan to deal with the problem or problems. This makes it difficult to get an idea of what was going on in the consultation.

   I accept the claim by [Dr B] it can be difficult managing the complex care of a patient who has as many ongoing health issues as [Mrs A]. [Mrs A] has a history of hypogammaglobulinaemia, asthma, bronchiectasis, sinusitis, obesity, and hypertension. It is difficult to monitor each condition with its ongoing problems and still hear when a patient mentions symptoms of a new problem. Without reliable records though, it is impossible to be sure what did transpire at the consultations and see whether [Dr B] did 'adequately assess the patient's condition, taking account of the patient's history and his or her views and examining the patient as appropriate.'

   [Mrs A] says she complained of rectal bleeding and discomfort. There is no record of that in her notes. There is an implication that something was said about her bowels or bowel habit at the April consultation because ultraproct (cream for haemorrhoids or anal irritation) was added to the list of prescriptions that day. However, we do not know what was said and we do not know what was done. There is a difference of memory of the facts between [Mrs A], who says she complained of rectal bleeding and discomfort and was not examined at all, and [Dr B], who says she would have done a full history and examination of this system as she had a medical student with her. [Dr B] acknowledges her notes from that day do not support her claim.

   [Mrs A's] consultation with [Dr B] on June 11 2009 seems to be mainly about a back injury.

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It is harder to know what the one on July 27 was about. A prescription was given for all her usual medications, plus more ultraproct. There is reference to an "action plan" but it is not clear what this is about. Her somac (pantoprazole) is changed to solox (lansoprazole) and inadvertently called solax but the script is written for lansoprazole so luckily no harm was done. We do not know what was discussed at the consultations though because of the scant written records. Presumably something was mentioned about [Mrs A's] bowels to continue the ultraproct, but again, no history, no examination, and no plan is recorded.

Given the high incidence of bowel cancer in New Zealand, especially in people over the age of 50, I would expect [Dr B] to record some information about [Mrs A's] bowels at one of the consultations where ultraproct is prescribed. It is not safe to assume rectal problems are always from haemorrhoids even in someone with a known history of this problem. The basic examination should have included a palpation of the abdomen and a visual inspection of the anus with a digital rectal examination. Possible extra investigations would be a check of blood iron level, faecal occult blood testing (if there was no obvious rectal bleeding) and consideration of referral for colonoscopy.

Recording the examination findings is just as important as ordering tests, as it forms the first part of the diagnostic process, without which it is impossible to "take suitable and prompt action" as required by the Medical Council. In a practice like [the medical centre], where patients are regularly seen by different doctors, it is crucial to record this sort of information for the benefit of the other doctors who may need to follow up on a problem.

At the consultation on December 30 [Dr B] writes a referral letter for [Mrs A] to have a colonoscopy for her abdominal problems, but the letter is not sent. In my opinion if this were an isolated slip it may be understandable, but on top of the poor documentation over the year, it indicates a lack of appropriate standard of care.

3. [Dr B] has proposed sensible changes to her practice. How adequate they are will depend on how well they are adhered to.

Discussion:
On page 6 of her letter to the Health and Disability Commissioner from 24 March 2010, [Dr B] says she will 'when a patient presents with anal, rectal, abdominal, or bowel symptoms or complains of other gastro-intestinal related symptoms I will always perform a full examination and order appropriate tests to exclude other pathology'. This is likely to happen as a natural consequence of missing a significant diagnosis.

The suggested audit of her patients on Ultraproct or Proctosedyl is a good idea to check how these other patients have been managed.

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She claims that she and other [medical centre] staff will ensure their documentation is completed as per the RNZCGP Cornerstone guidelines. These guidelines are very comprehensive and I think it would be more reasonable to say they will use these to audit notes regularly and see where and how they can continue with improvements in the quality of their notes. The specific part of [Dr B's] records which I think is substandard, is the consultation record, which needs to be more structured to provide some history, some examination findings and some plan.

From the notes I have seen it looks as though many of the practice documentation processes at [the medical centre] are working reasonably well — recalls for cervical smears, influenza vaccines and documentation of medications and demographic details seem appropriate. In the meantime I hope [Dr B] will personally write improved consultation notes for her use and the use of other doctors in the practice.

The practice computer systems are different from those I have used so I cannot tell how robust the 'protocol for the management of Provider Inbox results and correspondence' is. I suspect the robustness of the protocol depends on its implementation. It is good to have a system where different providers review the results of those ordering tests who may be away when the results come in. The important part is the level of commitment the other providers have when they review the results and how they decide what is to be done next. The 'other provider' will need to be a doctor who can interpret the results in light of the patient's history, and this will also require the consultation notes of be of a higher standard than we have seen from [Dr B]. I am not sure whether I would accept the 'other provider' being a nurse looking for abnormal results and then discussing these with a doctor. Sometimes apparently normal results can be abnormal for a particular person, or can be part of a trend which shows something needs to be checked further.

4. There is one other small aspect of the care provided by [Dr B] which I think supports my claim that she tends to lack care with her documentation. It is the copy of a referral letter from her to Dr […] for a skin tag excision on [Mrs A] in 2006. The letter does not say anything about where the skin tag is or what size it is which I think would be considered basic facts to help Dr […] prepare for the surgery before he sees [Mrs A].

5. In summary, the two departures from acceptable standards of care we can see are:
    - [Dr B's] written records are not adequate,
    - she failed to send an important referral letter, hence not 'taking suitable and prompt action when needed'.

The possible departure from care is that she did not appropriately listen to her patient, take a focussed history and examine [Mrs A's] abdomen when she should have. This last departure is hard to prove.

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In my opinion, the severity of the departure from acceptable standards of care is likely to be regarded by [Dr B's] peers with moderate disapproval.

[The medical centre] (trading as [the medical centre])

1. Please comment on the adequacy of the systems and processes in place at [the medical centre], particularly in relation to appointments, continuity of care, documentation, referrals and follow-up. If you believe that any of the systems and processes were not adequate, please indicate whether it would be viewed with mild, moderate, or severe disapproval by the providers' peers.

2. Please comment on the adequacy of the changes that have been made since the events complained about.

1. Many of the systems and processes in place seem, from the notes and letters provided, to be adequate.

   Discussion:
   There seem to be good systems for following up recalls for smears and flu shots. The demographic data held by the practice appears reasonably complete and the recording of patient contacts, medications and past medical conditions are all used appropriately.

   If it is true that [Mrs A] was told she had an appointment with [Dr B] and it was known that she would not be having an appointment with her, that would seem dishonest and inappropriate. It is possible there was a genuine misunderstanding around this, but I would hope the practice would use this to try and improve communication with patients when appointments are being booked.

   I think the main problem with continuity of care in the notes of this patient seems to be the paucity of notes made by [Dr B]. This would make it hard for other doctors to continue the care of this patient. Whether that happens in the notes of other patients in the practice I do not know.

   I am not an expert in practice management and do not have access to enough information about the practice systems to comment on these in any more detail.

2. The system changes made since this complaint include:

   Introducing an electronic referral management system (ERMS). This seems a good move, especially in a practice as busy as this (I am basing my assumption of busyness on the hours of the practice and the use of 10 minute, 15 minute and some double-booked appointment times).

   The Appointments Policy sounds reasonable, but as with all policies it will depend on the implementation of this by the staff.

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> The policy for tracking of test results, medical reports and investigations sound reasonable as far as it goes. It does not explain how 'another provider' will check the inbox for a doctor who is away.
>
> The referral protocol similarly sounds good if it is adhered to. It might be a useful feature of the programme for the 'Referral information for Patients' to become available only when the referral has been sent, but I do not know if that would be do-able or not.
>
> All these protocols require a combined effort by the practitioner requesting the referral or test and the administrative staff. They need to help each other check they have done what they say they are doing.
>
> In conclusion, the changes that have been made since the events complained about seem adequate to me. The important thing is that the proposed changes are implemented."

On 13 December 2011 HDC asked Dr Corkill to provide the following further advice:

> "In September 2008, [Mrs A] weighed 111.7kgs. This had dropped to 99kgs on 27 July 2009 and 93.4kgs on 30 December 2009. [Dr B] has acknowledged that [Mrs A's] weight loss was a 'red flag' but added that [Mrs A] had always been encouraged to lose weight and that she had been doing this steadily since September 2008. [Dr B] has noted that in hindsight it is easy to attribute [Mrs A's] weight loss to the subsequent cancer diagnosis, but that at the time, it seemed consistent with her efforts to lose weight, and her diarrhoea.
>
> 1. Can you please comment on the adequacy of [Dr B's] care in this regard? Was it reasonable for [Dr B] not to consider a more sinister cause for [Mrs A's] weight loss during this period (April–December 2009)?
>
> 2. Was the cause of [Mrs A's] diarrhoea adequately investigated by [Dr B]?"

Dr Corkill provided the following advice:

> "1. The amount of weight loss from 111kg to 93.5kg over 15 months is significant. It is a red flag for consideration of a sinister diagnosis such as bowel cancer. [Dr B] accepts this (in her letter to the Health and Disability Commissioner page 2).
>
> [Dr B] presents mitigating factors in her defence. These are that [Mrs A] was being encouraged to lose weight by her doctors and that she was being seen by several different doctors over this time. [Dr B] also notes the weight loss was steady over this period. Between 4.9.08 and 16.1.09 [Mrs A's] weight dropped from 111.7kg to 104.5kg, then on 5.5.09 to 100.7kg, on 27.7.09 to 99kg and on 30.12.09 she is 93.4kg. The steadiness of the loss makes it harder to determine at what point it becomes significant. Although [Mrs A] says she was not trying to lose weight, her doctors,

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including [Dr C] (respiratory specialist [public] hospital) seem to think she was trying to.

By the last consultation on 30.12.09 [Dr B] had decided to refer [Mrs A] to a specialist, but at this point omits to send the referral.

My answer to your further question is yes, the amount of weight loss is significant and should be regarded as a red flag to a significant problem. However, I accept the explanations offered by [Dr B] as realistic mitigating factors in the interpretation of its significance. Her failure to act on this "red flag" is a departure from the desired standards of good medical care. I think our peers would regard this aspect of the care as an understandable oversight in the circumstances, and therefore of minor degree.

2. With the benefit of hindsight it is apparent that [Dr B] did not adequately investigate [Mrs A's] diarrhoea, but it is hard to tell at what point [Dr B] actually knew about the diarrhoea. It is not mentioned in the general practice notes until November 2009, but I have already pointed out the notes are brief and so it may have been mentioned and not recorded. Consequently I am unable to say whether [Dr B] was falling below expected standards of care in respect of her investigation of the diarrhoea.

[Dr C] commented that [Mrs A] thought she might have been having diarrhoea from her antibiotic and suggested a different antibiotic — I see no need for [Dr B] to have followed up on this until she saw [Mrs A] again. Then in November 2009 [Mrs A] saw [another doctor] where the diarrhoea was mentioned and recorded and he started investigations by getting a faeces sample checked for bacteria and giardia. Someone at the practice seems to have followed up on this a month later when the result was noted to be negative and [Mrs A] was phoned and asked whether she was still having problems and if so, to come in to discuss this problem again. That is appropriate, and the plan by [Dr B] to refer [Mrs A] for a colonoscopy at that point was also appropriate. I note she also ordered coeliac antibodies and prescribed imodium at this time so she was investigating and taking notice of the diarrhoea then. It is really unfortunate that the referral for the colonoscopy was not sent.

I do not see any evidence that [Dr B] had opportunity and therefore responsibility to investigate the diarrhoea earlier than late 2009."

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