

General Practitioner, Dr C

**A Report by the
Health and Disability Commissioner**

(Case 01/08770)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Complainant, consumer's mother
Mr B	Consumer
Dr C	Provider, General Practitioner
Ms D	Customer Services Manager, a public hospital

Complaint

On 10 August 2001 the Commissioner received a complaint from Mrs A concerning the services provided to her son, Mr B, by Dr C, general practitioner. The complaint is summarised as follows:

Dr C did not provide Mr B with services of an appropriate standard and sufficient information during and after Mr B's consultation with him on 13 February 2001. In particular Dr C:

- *Told Mr B the lump was probably a cyst and nothing worry about, despite Mr B asking if it was cancer.*
- *Did not explain clearly the importance and urgency or the need for the recommended ultrasound.*
- *Did not have a 'bring-up' system to monitor the arrival of test results and to notify the patient of the results or, if the patient has not had the test, to follow up with the patient to reinforce the need to have the test done.*

An investigation was commenced on 8 March 2002.

Information reviewed

- Complaint letter and correspondence with Mrs A
- Notes of an interview with Mr B conducted on 13 May 2002
- Response from Dr C, dated 9 April 2002
- Medical records from the public hospital and a private imaging company, received 7 June 2002
- Medical records obtained from Mr B's current GP
- Transcript of a tape-recorded statement made by Mr B, played by Mrs A at an advocacy meeting, December 2001. The transcript was made, and provided to me, by Dr C.

Independent expert advice was obtained from Dr John Cheesman and Dr Jim Vause, general practitioners.

Information gathered during investigation

On 13 February 2001 Mr B, aged 25 years, consulted Dr C, general practitioner at a medical centre which advertises as specialising in men's health. Mr B did not have a regular general practitioner as he had recently returned from overseas and kept good health. Mr B had noticed and had become concerned about a lump on his left testicle. He chose Dr C because he specialised in men's health issues. Mr B had noticed the lump about a week prior to the consultation.

At the consultation Dr C asked Mr B about his history and was advised that he suffered slightly high blood pressure. In my provisional opinion I stated that Mr B did not advise Dr C that he had experienced an undescended testicle as a child, requiring corrective surgery. Both parties commented on this matter in response to my provisional opinion. Mrs A noted that Mr B had never had surgery for a testicular problem, and was not in fact aware that he had ever had a testicular problem. Dr C, in his response, noted that based on the history described by Dr E, an oncologist, in his letter to Dr C of 18 July 2001, Mr B never had an undescended testicle and that the description was instead indicative of a retractile testicle, which is of much less clinical significance. It is clear that Mr B did not have corrective surgery as a child.

Mr B told Dr C that the lump was not tender or painful and that his sexual function was normal. He further advised that he was not aware of any contact with sexual disease. Mr B does not recall discussion around the issue of sexually transmitted disease, but this conflict is not relevant in the circumstances of this case. Mr B described the lump as "a knot which went intermittently harder/softer". Dr C found the lump difficult to find and needed Mr B's help to guide him to where the lump was. On finding the lump Dr C described it in his notes as:

"Definite lump approx 5mm in area of (L) epididymis. ?Epid cyst."

It appears that the lump may in fact have been in the body of the testicle itself, rather than in the epididymis (a sperm-carrying duct), given the subsequent diagnosis of testicular cancer. However, in response to my provisional opinion, Dr C referred to a letter from Dr E dated 25 July 2001, in which he refers to the histology report disclosing a "pure seminoma of the testis and part of the epididymis". Dr C points out that the malignancy clearly involved the epididymis, and thus there is a likelihood that his initial examination and assessment of the positioning of the lump was in fact accurate. I accept that the letter from Dr E does establish that the malignancy involved the epididymis as well as the body of the testicle. There is insufficient evidence for me to conclude that Dr C's assessment of the positioning of the lump was wrong. I shall proceed on the basis that his assessment was accurate.

Dr C told Mr B that he believed the most likely diagnosis was a harmless cyst in the epididymis. Mr B asked Dr C whether the lump was cancer. Dr C replied that testicular cancer was "fairly rare" but that he was in the "at risk age group". Dr C said that the diagnosis could not be established on clinical grounds alone and that an ultrasound scan was needed to confirm it. Dr C informed me that he discussed with Mr B the case of another

young man who had developed aggressive and terminal testicular cancer; he maintains that Mr B was aware of the possibility of cancer. The transcript of Mr B's tape-recorded statement played at the advocacy meeting in December 2001 corroborates Dr C's view. The recorded statement refers to Dr C discussing the case of a man with testicular problems, although cancer was not specifically mentioned.

I am satisfied that Dr C indicated to Mr B that he thought the most likely diagnosis was a benign cyst, but that he did discuss the alternative more serious scenario of cancer, and said he could not rule it out at that stage.

At the end of the consultation Dr C completed an ultrasound requisition form for Mr B to undergo an ultrasound at a private medical imaging company. Mr B was unsure whether his health insurance would cover the cost of the scan. Dr C stated that it was agreed that Mr B would arrange his own appointment for a scan if his insurance covered it, and would follow up with Dr C if he did not have health insurance and required a referral to be made through the public hospital outpatients department.

There is a direct conflict in the evidence regarding what Dr C said to Mr B in relation to the issue of getting the ultrasound performed. Dr C informs me that he clearly indicated the need to get the scan done and would have arranged the appointment at the time of Mr B's consultation, but that Mr B requested that he follow it up himself after checking his insurance status. Mr B, on the other hand has informed me that Dr C was far more equivocal regarding the need to perform the ultrasound. He informed me that Dr C presented him with two options: either he could get the scan done immediately, or he could monitor it for a period of time to see if there were any changes in the lump.

On balance, I am satisfied that Dr C did recommend that an ultrasound be performed. There are a number of factors on which I have based this assessment. Primarily, Dr C has emphasised to me that his initial management plan – and usual practice – was to arrange a scan during the actual consultation. The sole reason he did not do so in this case was because Mr B requested to make the appointment himself once his insurance status had been clarified. Dr C is also quite clear in his notes, which record: "Plan: scan testicles". The notes do not suggest it was an option for Mr B to monitor the lump. From the time the complaint was first brought to his attention, Dr C has consistently maintained that he told Mr B that he should have a scan. It may well be that because Dr C discussed the possible delays in treatment if a scan were arranged in the public health system, Mr B's recall of the advice Dr C gave is clouded by this discussion.

Accordingly, I proceed on the basis that Dr C advised Mr B that he should get a scan performed.

Mr B informed me that he left Dr C's rooms feeling relieved. He said that over the following months there were some very minor changes to the nature of the lump, but because he had been reassured by Dr C's comments he felt he did not need an ultrasound. Mr B decided to have an ultrasound only when, some months later, his mother persuaded him to attend because his lump was still present.

On 10 July 2001 Mr B attended a private imaging clinic for an ultrasound and was subsequently diagnosed with testicular cancer.

Independent advice to Commissioner

Dr John Cheesman

The following expert advice was obtained from Dr John Cheesman, an independent general practitioner:

“Documentation received:

1. Correspondence with [Mr B] and his mother (A).
2. Correspondence with [Dr C] and attachments (B).
3. Medical records from [Mr B’s GP] (C).
4. Medical records from [the public hospital] (D).

In response to questions:

[Mr B] consulted [Dr C] on the 13th February 2001 with the history of a lump in his left testicle, which he had noticed for approximately one week. He also said that the lump felt like a knot within the testicle. [Dr C] examined [Mr B] and made the comment that he could feel a definite lump which appeared to be in the area of the left epididymis and he thought that this was possibly a cyst.

[Dr C] told [Mr B] [that] this was ‘Highly unlikely’ to be cancer and suggested an ultrasound scan of the testicle and [Mr B] said he was told he could have this either ‘straightaway or in a few months time to monitor progress’. However [Dr C] said that he told [Mr B] that cancer could not be ruled out without an ultrasound scan. [Dr C] said that he told [Mr B] that whilst testicular cancer was fairly rare, he was in the ‘at-risk’ group for it. (This is not actually recorded in the clinical notes.)

In my opinion I do not feel that the advice given to [Mr B] emphasised enough the real possibility of testicular cancer and the need to get an ultrasound scan done reasonably quickly to rule out that possibility. This was particularly so because of the potential risk of testicular cancer in someone in this age group (malignancy needs to be ruled out in a young man with a painless testicular swelling) and also because of the past history of undescended testicle. (There is a probable link between undescended testicle, even if corrected by surgery, and the development of testicular cancer).

I feel because of the above, [Dr C] should have definitely followed up on his referral to check that the ultrasound examination had actually been attended, particularly since

some time had elapsed since seeing [Mr B]. (Five months until he received notice that examination had been done.) I feel [Dr C] should have followed this up if he had not had the result of the ultrasound within several weeks, no later than one month.

For this and other situations, particularly with the potential for serious consequences, I feel there should be a system for checking to see whether tests, investigations and referrals have actually been performed or attended within a designated timeframe (i.e. a 'bring up' process).

[Mr B] was seen the day after the ultrasound was done to discuss further management.

This was quite appropriate and I do not believe that there are any other issues regarding [Mr B's] care that warrant further exploration."

Dr Jim Vause – initial advice

Additional expert advice was sought from Dr Jim Vause, an independent general practitioner:

"Declaration

I know [Dr C] professionally from previous work. He was a member of a team working with me on the development of injury guidelines for the ACC some 3 years ago. I do not know him in any social context. I do not know [Mr B's family].

In reply to your specific questions:

In your opinion, given [Mr B's] presentation on 13 February 2001, was [Dr C's] examination, diagnosis and action appropriate?

Yes, with the following exceptions.

The identification of [Mr B's] previous history of an undescended testicle and orchidopexy (operation to lower an undescended testicle in a child) is not recorded in [Dr C's] records of 3 Feb. 2001 but is present in his referral letter to [Dr E] of 16 July 2001. Therefore I cannot accurately ascertain whether [Dr C] had elicited this at the time of his first examination of [Mr B] on 13-02-01 or at the second consultation on 11-07-01.

This is of relevance as an undescended testicle (even after surgical correction) raises the risk of subsequent cancer up to 7 times the normal (depending on various other factors)¹ and would therefore influence a general practitioner's assessment as to the likelihood of [Mr B's] scrotal lump being cancer.

Examination:

On the examination of [Mr B], [Dr C] clearly identifies [Mr B's] lump as being in the "area of the left epididymis".

Such a finding is of importance, as it would have influenced [Dr C] in his assessment of the risk of this lump being cancerous. The epididymis lies outside the body of the testicle. The below quote is from a 2000 Londonderry, Northern Ireland study for 582 men who had scrotal ultrasounds:

'The cause of the scrotal swelling was mainly extratesticular (75% of all scrotal swellings), hydrocele being the commonest. Of the intratesticular causes, infection (50.8%) and tumour (20.6%) were the commonest. In conclusion ultrasound examination distinguishes extratesticular (almost always benign) from intratesticular (potentially malignant) causes of scrotal swelling.'²

Thus the examination by [Dr C] seems appropriate, the problem being that all the retrospective evidence indicates that [Dr C's] examination diagnosis of an epididymal cyst was incorrect.

Actions:

Based on the information he had obtained in the history and examination above on the 3-02-01, I believe [Dr C's] actions as reported in his letter to the Commissioner of 9 April 2002 and his letter to [Mrs A] on 5-9-01 to be entirely appropriate except for the follow-up of the ultrasound. Unfortunately, his clinical notes on his actions are rather limited and there is a significant discrepancy between these recordings, [Dr C's] above letters and the account of [Mr B].

This is discussed below.

Should a higher standard of care have been expected given that [Dr C] was working in a clinic focusing on men's health issues?

There are two issues to be considered:

1. [Dr C's] vocational registration as defined by the Medical Council and the Royal New Zealand College of General Practitioners and
2. Advertising and promotion of a clinic as providing a practice more specialised than a normal general practice.

On the first:

[Dr C] is vocationally registered with the Medical Council of New Zealand as a general practitioner. His registered qualifications are [of note]. Therefore the professional standard of care to be expected is that of any vocationally registered general practitioner. Men's health is not recognised as a subspecialty within general practice and there is no 'specialist' qualification necessary to practice in such a clinic.

With respect to the services offered by [the clinic specialising in men's health], I have surveyed their website³ and all the procedures and examinations offered except

vasectomy and pilot medicals are in the realm of normal general practitioner expertise. Vasectomy is commonly carried out by some general practitioners with appropriate individual expertise. Pilot medicals are similarly the domain of some general practitioners with performance and experience criteria defined by the CAA.

Thus the services are entirely commensurate with [Dr C's] vocational registration assuming he has CAA recognition for aviation medicals and appropriate training and experience in vasectomies.

On the second:

The promotion/advertising of a clinic may give rise to a patient's belief that a clinic's doctor has a skill and expertise beyond that of most general practitioners. In the past, medical ethics did address this problem to some extent. However over the years the restrictions on advertising have been removed from ethics. Thus the ethical code of the NZMA does not cover this.

I have surveyed the Council of the RNZCGP on this matter and while we recognise the issue in 1. above as being correct, there remains a degree of disquiet on the promotion matter. I would be unwilling to comment further without consideration of the issue by the key stakeholders in the matter, namely professional, ethical, consumer and commercial groups.

Was the advice and information [Dr C] gave to [Mr B] appropriate?

Working from [Dr C's] notes, I cannot evaluate the advice as it is not documented.

Using [Dr C's] letter to [Mrs A] dated 5-9-01, his advice is entirely appropriate. He clearly wanted to perform a scan and does not refer to the options explained by [Mr B]. He does explain in the same letter that:

'I have always been careful not to lead the patient to believe that there is some serious condition without investigational evidence to back my conclusions'.

This is entirely appropriate assuming that the investigation is ordered and performed.

Working from [Mr B's] statements in the file note 01/087770, the appropriateness of [Dr C's] comments is harder to judge.

As per 01/087770, [Dr C] offered [Mr B] two options, one of which was to *'monitor it for a few months and ultrasound if there are any changes'*. This plan of action would seem appropriate but it places significant responsibility back on the patient, more so given the probable underestimating of the cancer risk as indicated above.

I have a degree of unease with this plan of action but the use of time to observe the progression of a problem is very common in general practice, especially as indication

for further investigation or action. If such a plan of action was contemplated, it should have been documented in [Dr C's] notes.

On the matter of the comment attributed to [the radiation oncologist] by [Mr B] that testicular lumps 'are cancer more often than not'.

If this is as reported, then the statement is misleading for [Mr B].

Testicular lumps are a not infrequent presentation to general practitioners while testicular cancer is not.

I have personally seen only two testicular cancers in 23 years of practice and according to a research I performed of our practice's computerised clinical records, I saw 2 patients in the year ending 1 September 2002 with testicular lumps. By contrast [Dr E] is a radiological oncologist and sees a highly select population of patients who all have cancer while a general practitioner is seeing an unselected population.

To reiterate from the aforementioned Londonderry 2000 study:

'The cause of the scrotal swelling was mainly extratesticular (75% of all scrotal swellings), hydrocele being the commonest. Of the intratesticular causes, infection (50.8%) and tumour (20.6%) were the commonest.'⁴

In further consideration of the likelihood of this lump being a cancer, there were 125 new registrations for testicular cancer in New Zealand in the year 1999 (statistics from NZHIS, 1999 being the latest figures I could obtain), giving a rate of 6.3 per 100,000 of the male population.

In that same year there were 3191 general practitioners in practice. Thus it could be expected that there was approximately a 1 in 30 chance that a particular general practitioner would have seen a case of testicular cancer in that year. This figure does not take into account the selective nature of [Dr C's] practice population (being all male) or the size of his practice population (a larger practice makes this likelihood greater).

Should [Dr C] have followed up on his referral to see whether [Mr B] actually attended for an ultrasound?

I believe he should have and this is also implicit from his comments in his letter to [Mrs A] of 5-9-01 as quoted above.

However, consideration must be made that at the time of [Mr B's] consultation with [Dr C], an explicit standard on the matter of follow-up of test results had not been established. I note that the timing of this incident was shortly before the first statement by the Commissioner on the matter of patient test results. Also it must be

considered that in Feb 2001 the reality was that most general practices did not have audit trails for test results.

In this case, the patient exercised the option not to have the test performed. This is not an unusual occurrence and from personal experience of using a test result audit trail, sometimes such patient exercised option to not perform a requested test is for problems that could be significant. Such circumstances place great importance on the discussion between [Dr C] and [Mr B] as to the likely nature of [Mr B's] lump and therefore the need for further investigation.

Are there any aspects of the care provided by [Dr C] that you consider warrants further exploration by the investigation officer?

On the issue of the accuracy of [Dr C's] identification that [Mr B] had a lump in the epididymus of his testicle, it is possible that such a lump was present in addition to his testicular cancer. While this is not supported by the ultrasound performed 5 months later showing no epididymal lump, rather the cancer in [Mr B's] testicle, the histological and operation report on [Mr B's] testicle removed at the time of the orchidectomy would further clarify this matter. Unfortunately I could not find these in the hospital records sent to me.

The other issue is the request form for the ultrasound written by [Dr C] and apparently given to [Mr B]. This may have information that could have influenced [Mr B's] understanding of the severity of his problem and could provide clarification on [Dr C's] actions.

[Mr B], in the file note of 01/08770 comments that when he went for the ultrasound scan 'There was no referral from [Dr C's]. [Dr C] in his letter of 5-0-01 to [Mrs A] refers clearly to the requisition form. The request form should be available from the radiologists at CMI.

Are there any aspects of the care provided by [Dr C] that you consider warrants additional comment?

No.

In summary,

1. It is probable, but by no means certain, that the risk of [Mr B's] lump being cancerous was underestimated by [Dr C] through misidentifying the position of the lump on examination (an easily enough made mistake) and failing to identify [Mr B's] previous undescended testicle and orchidopexy.
2. I cannot make a clear assessment of [Dr C's] subsequent actions. His clinical records are of little help except to indicate he ordered a scan. His report to the Commissioner identifies that he took correct steps. [Mr B's] report on the advice he

was given indicates he was reassured that the lump was unlikely to be a cancer and this is reflected in his actions in not obtaining the ultrasound examination based upon this. There are many subtleties in doctor patient communication and assessing this in retrospect and isolation is next to impossible.

3. Much of the problem arises from the lack of follow up by [Dr C], either repeat clinical examination or follow-up of the unperformed ultrasound. The consultation occurred at a time when there was not a clear standard on the follow-up of test results. This case strongly supports the need for such systems to follow-up test results, especially now that these can be implemented relatively easily with computerised patient management systems.

4. The practice of giving a patient a requisition form for an investigation of this potential significance places great emphasis on the advice given to the patient on the necessity for the investigation. In addition to the importance of this advice for informed consent as to the need for the test, the availability, timing and possible cost of a test, doctors need to consider the ‘transfer of care’ that is implicit in a request for investigation. I feel it is more appropriate for a doctor to make the referral direct to the agency that he/she and the patient have chosen for the investigation. This would assure transfer of care, facilitate audit of test results and might provide some protection to the general practitioner in circumstances such as this. As part of this, practices should keep a copy of the requisition request form.

I trust this information is of help to the Commissioner.

1 A J Swerdlow, C D Higgins, M C Pike *Risk of testicular cancer in cohort of boys with cryptorchidism* BMJ 1997;314:1507 (24 May)

2 Micallef M, Torreggiani WC, Hurley M, Dinsmore WW, Hogan B. *The ultrasound investigation of scrotal swelling*. Int J STD AIDS 2000 May;11(5):297-302

3 On line at [...]

4 Micallef M, Torreggiani WC, Hurley M, Dinsmore WW, Hogan B. *The ultrasound investigation of scrotal swelling*. Int J STD AIDS 2000 May;11(5):297-302”

Dr Jim Vause – further advice

After receiving Dr Vause’s advice, the Commissioner sought additional information including the histological and operation report on Mr B’s testicle removed at the time of the orchidectomy and the request form for the ultrasound. This information was forwarded to Dr Vause, who provided additional comment as follows:

“Thank you for obtaining the relevant documentation.

The ultrasound request form supports both the statement made by [Dr C] and his clinical records that he suspected the scrotal lump was an epididymal cyst. It also

confirms that he requested an ultrasound scan when he saw [Mr B]. It does little to clarify the nature of the communication between [Dr C] and [Mr B] as to the need for this investigation (the request form has been ticked as 'non urgent').

The histological report merely confirms the diagnosis of cancer. There is no report of an epididymal cyst but equally there is no specific reporting of the clinical appearance of the epididymus.

Overall the ultrasound scan request confirms [Dr C's] account of his consultation with [Mr B] in February. Otherwise my opinion on this case is not changed."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

- 1) *Every consumer has the right to have services provided with reasonable care and skill.*
 - ...
 - 4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*
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Opinion: No Breach – Dr C

Communication with Mr B

There was a concern that Dr C advised Mr B inappropriately about his risk of cancer and the importance of obtaining an ultrasound. My opinion is that Dr C did not breach the Code of Rights in respect of his communication with Mr B when he presented on 13 February 2001. I consider that Dr C appropriately advised Mr B regarding the risk of cancer and his need to have an ultrasound performed.

Dr C advised Mr B that the lump was not likely to be cancer but that it could not be ruled out without a scan. Dr C discussed the case of a young man with an aggressive testicular cancer and referred him for a scan. I consider that Dr C gave appropriate advice to Mr B. Mr B did not display high risk factors that might have made Dr C's advice – that cancer was unlikely – inappropriate. I note in this context the advice I received from my expert advisor,

Dr Vause, that “testicular lumps are a not infrequent presentation to general practitioners while testicular cancer is not”.

Dr Vause referred to two factors that would increase the risk of Mr B’s lump being cancer: the positioning of the lump, and the issue of a previous history of undescended testicle requiring corrective surgery. In my opinion, there were no features of Mr B’s presentation or history as assessed by Dr C – other than his age – that placed him in a high-risk category.

On balance, I am not satisfied that Dr C incorrectly assessed the position of the lump during the initial consultation. Consequently, I cannot conclude that Dr C should reasonably have assessed the positioning of the lump as increasing the risk of Mr B having cancer. Nor did Mr B have a history of undescended testicle; his medical history did not display any factors that would have increased the chance of his lump being malignant.

Dr C did not suggest that an ultrasound was optional, or that it could wait. He did suggest that it was more likely to be benign than malignant, but this was statistically correct and reasonable advice, especially as Mr B did not display any particular risk factors. On the information known to him at the time, Dr C gave appropriate advice, in stating that cancer could not be excluded without a scan, and referring Mr B to get one performed. On balance, I do not consider that Dr C downplayed the risk that Mr B presented.

It is tragic that Mr B felt sufficiently reassured by Dr C’s view that the lump was not likely to be cancer. But I do not consider that Dr C can be held responsible for the delay that occurred in getting the scan performed.

Accordingly, in my opinion Dr C did not breach the Code in respect of his assessment of Mr B’s condition or the advice he gave to Mr B.

Opinion: Breach – Dr C

Follow-up of the referral

There was a further concern that Dr C did not have an adequate ‘bring-up’ system or a procedure to follow up referrals for tests. My opinion is that Dr C breached Right 4(4) of the Code of Rights in respect of his failure to follow up his referral of Mr B for an ultrasound and therefore failed to provide a service that minimised potential harm to his patient.

Dr C recommended an ultrasound for Mr B because he considered that the lump, while not likely to be cancer, needed to be checked with an ultrasound scan. In this case, it was left to Mr B to action the referral once he had determined his insurance position. Dr C informed me that what happened with Mr B was not his normal practice, in that he usually arranges further investigations at the time of the consultation, and fell outside of his usual follow-up system. Dr C did not follow up the matter with Mr B.

In my view, any tests or investigation ordered *where the doctor has reason to suspect a diagnosis of malignancy* requires prompt follow-up by the requesting doctor. In assessing

the doctor's follow-up, it is no excuse that the reason for any delays in the results may be outside the practitioner's control – for example, administrative error or the patient's decision not to have the test or procedure performed. The duty to follow up the missing results remains. At the least, the doctor needs to make reasonable enquiries as to why the test results have not become available. As noted by Dr Vause, "This case strongly suggests the need for ... systems to follow-up test results, especially now that these can be implemented relatively easily with computerised patient management systems."

Both my independent advisors agree that Dr C should have followed up on his referral to see whether Mr B actually attended for an ultrasound, either through repeat clinical examination or use of a system to check whether referrals have actually been performed or attended within a designated time frame.

As noted by the South Australian Supreme Court in 1998, it is "unreasonable for a professional medical specialist to base his whole follow-up system, which can mean the difference between death or cure, on the patient taking the next step" (*Kite v Malycha* [1998] SASC 6702).

In my opinion, in not having an appropriate bring-up system in place and failing to follow up the referral in a timely manner, Dr C did not provide services to Mr B in a manner that minimised potential harm, and therefore breached Right 4(4) of the Code.

While Dr C did have a bring-up system – and in this respect was ahead of many of his colleagues at the time – this does not alter my view. Unfortunately, in this case, his system allowed Mr B to fall through the cracks. However, it would be wrong to suggest that Dr C bears sole responsibility for the delay in having the ultrasound. In the final analysis, the decision not to get the scan performed promptly was made by Mr B, and there is no evidence that his decision was based on advice from Dr C that doing nothing was an appropriate option.

Other comments

Transfer of care

Dr Vause advised me that when making a referral, general practitioners need to consider the transfer of care that is implicit in this action. Dr Vause stated that it is more appropriate for a general practitioner to make a direct referral to the agency that the patient has chosen for the investigation, rather than simply giving the patient a request form. I accept Dr Vause's advice that a direct referral ensures transfer of care, facilitates the audit of test results and may provide the general practitioner with a degree of protection should the patient decide not to attend an appointment (although ultimate responsibility for following up on test results remains with the general practitioner).

Actions taken

I would like to commend Dr C on the steps he has since taken to review his practice and policy as a result of this matter. Dr C has changed his bring-up system to cover the situation that occurred in this case, where he does not refer the patient directly to another provider. I also note with approval that [the medical centre specialising in men's health] has commissioned a new computer system that will further facilitate the follow-up of patient test results.

Recommendations

I recommend that Dr C apologise in writing to Mr B for breaching the Code. This apology is to be sent to the Commissioner and will be forwarded to Mr B.

Further actions

A copy of this report will be sent to the Medical Council of New Zealand.

A copy of this report, with identifying details removed, will be sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.
