General Practitioner, Dr B

Medical Centre

A Report by the

Health and Disability Commissioner

(Case 15HDC00792)

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Executive summary

1. Mr A was aged 58 years at the time of the events in question. His regular general practitioner (GP) at his medical centre was Dr C. From time to time Mr A consulted Dr B, another GP employed at the medical centre.

2. Mr A consulted Dr B on 23 December 2013 with symptoms of epigastric[1] pain (which had been present for one month), difficulty swallowing, increased wind, and weight loss.

3. Dr B recorded Mr A's weight as being 84 kilograms. She also recorded that Mr A had not been trying to lose weight. At the time, Dr B was unaware of the extent of Mr A's weight loss and understood that the weight loss was a result of lifestyle changes, which were being overseen by Dr C. Mr A's weight loss was therefore not concerning to Dr B. Dr B formed a working diagnosis of gastritis. She arranged blood tests (the results of which were normal) and prescribed Mr A omeprazole 40mg and Metamide 10mg.

4. On 3 February 2014 Mr A consulted Dr B for review and complained of ongoing difficulty swallowing. Dr B's plan was for Mr A to continue with his lifestyle changes and to return if his symptoms continued. She did not weigh him at this consultation.

5. Mr A next saw Dr B on 29 April 2014. He told her that he had lost a further six kilograms, felt tired and had continued difficulty swallowing. Dr B reviewed earlier clinical notes and found that in 2012 Mr A had weighed 93 kilograms. At this visit Mr A weighed 78 kilograms. Dr B ordered repeat blood tests (including for anaemia and CEA[2]) and a chest X-ray, and formed a "possible plan" to refer Mr A for a gastroscopy.[3]

6. Dr B reviewed Mr A again on 8 May 2014. He complained of gastric pain, burping, and general discomfort, and felt as though food was getting stuck in his oesophagus, but he did feel that he had put on some weight. Dr B was reassured by this, but she did not weigh Mr A. She advised him to take regular omeprazole and to return for further review and a referral for a gastroscopy if he was not feeling better.

7. On 19 September 2014 Mr A consulted Dr C, who referred him that day for an urgent oesophagoscopy[4] and concurrently for a barium swallow.[5] The oesophagoscopy revealed a signet-ring carcinoma[6] in the lower oesophagus, which was later treated with radiotherapy and chemotherapy.

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[1] Upper central region of the abdomen.
[2] Carcinoembryonic antigen: a tumour marker.
[3] A form of endoscopy (examination of a body cavity or organ using an optic instrument) of the inside of the oesophagus, stomach, or duodenum (the first part of the small bowel).
[4] A form of endoscopy involving examination of the oesophagus.
[5] An X-ray imaging test used to visualise the structures of the oesophagus.
[6] A rare type of cancer found most often in the glandular cells lining the stomach. Under a microscope the cells look like signet rings.

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Findings

8. By failing to assess Mr A appropriately and arrange for him to be referred urgently for an endoscopy on 23 December 2013, 3 February 2014, 29 April 2014 and 8 May 2014, Dr B failed to provide services to Mr A with reasonable care and skill and, therefore, breached Right 4(1)[7] of the Code of Health and Disability Services Consumers' Rights.

9. The medical centre was found not to have breached the Code or to be vicariously liable for Dr B's breach of the Code.

Recommendations

10. The Commissioner recommended that Dr B:

a) Arrange for an independent general practitioner peer to conduct:

i. a qualitative review of a random selection of 30 patients' consultation notes that Dr B had completed within the last 12 months, to determine whether appropriate assessment and review had occurred in response to presenting symptoms; and

ii. a random audit of ten referrals to specialist secondary services that Dr B had instigated within the last 12 months, to check that appropriately documented requests had been performed and appropriate reminders had been put in place to follow up such referrals.

b) Undertake appropriate training in the use of CEA tumour marker tests, in conjunction with the Royal New Zealand College of General Practitioners.

c) Provide a written apology to Mr A for the failures identified in this report.

Complaint and investigation

11. The Medical Council of New Zealand forwarded to the Commissioner a complaint it had received from the Accident Compensation Corporation regarding the services provided to Mr A by a general practitioner (GP), Dr B. Mr A supports the complaint.

12. The Commissioner identified the following issues for investigation:

- *The appropriateness of the care provided to Mr A by Dr B.*
- *The appropriateness of the care provided to Mr A by the medical centre.*

13. An investigation was commenced on 29 October 2015.

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

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14. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	General practitioner
Dr C	General practitioner
Medical centre	Provider

15. Information from the Accident Compensation Corporation was also reviewed.

16. In-house clinical advice was obtained from GP Dr David Maplesden (**Appendix A**).

Information gathered during investigation

Consultations — Dr B

17. Dr C[8] was Mr A's regular GP at the medical centre. From time to time when Dr C was not available, Mr A consulted Dr B,[9] another GP employed at the medical centre. Dr B had been employed at the medical centre since 2010.

23 December 2013

18. On 23 December 2013 Mr A (aged 58 years at the time of these events) presented to Dr B with weight loss and symptoms of epigastric[10] pain, difficulty swallowing food, and increased wind.

19. Mr A said that he told Dr B that he had been losing weight, was having trouble eating, and had difficulty swallowing.

20. Dr B examined Mr A's lower abdomen and recorded that the findings were normal. She told HDC that on examination Mr A was afebrile,[11] and his weight was recorded as 84 kilograms. Dr B recorded in the clinical notes:

> "Has epigastric pain for a month, has not been trying to lose weight, feels like food will not go down, dull ache in the middle of the night, no heartburn, more wind, no nausea, no vomiting, bowels normal. E: has epigastric tenderness afebrile lower abdomen. A: Gastritis [review of] helicobacter … for blood tests before next appointment form given [review] with results, may need further investigations."

21. Dr B said that she was not familiar with Mr A's background, and did not review the clinical notes "as far back as a year" because his symptoms were of only a month's duration.

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[8] Dr C has been vocationally registered in general practice since 2000.
[9] Dr B obtained vocational registration in 2011. She is a Fellow of the Royal New Zealand College of General Practitioners.
[10] Upper central region of the abdomen.
[11] Without a fever.

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22. Dr B said that she understood that Mr A's weight loss was a result of lifestyle changes, which he had instigated in order to decrease his lipids,[12] and which were being overseen by Dr C. Dr B said that she believed that the weight loss was in keeping with Mr A's "stated attempt to lose weight over an extended period of time". Dr B told HDC that she did not have the impression that Mr A's weight loss was progressive or unexplained and, as such, she was not concerned with his weight loss at that time.

23. Dr B said that she was reassured that the cause of Mr A's symptoms was not "something more sinister such as oesophageal cancer" because he did not report any vomiting, pain on swallowing, chest or back pain, a hoarse voice, bleeding into the oesophagus or chronic cough.[13]

24. Dr B told HDC that in light of Mr A's symptoms and her examination findings, her working diagnosis was gastritis, and that she "managed [her working diagnosis of Mr A's] symptoms accordingly and considered that it was reasonable to defer referral". She prescribed Mr A omeprazole[14] 40mg and Metamide[15] 10mg and arranged blood tests including a full blood count and a test to rule out *Helicobactor pylori*.[16]

25. Mr A's blood test results were received on 24 December 2013, and were normal. Dr B told HDC that she made an entry in the notes that Mr A might need follow-up, "to prompt [her] or [Dr C] in case Mr A had ongoing concerns".

3 February 2014

26. On 3 February 2014 Mr A consulted Dr B again for review and complained of ongoing difficulty swallowing.

27. Mr A told HDC that he "knew the medication was not working" and saw Dr B again because Dr C was busy with other patients. Dr B told HDC that Mr A told her that his "symptoms were better", and that swallowing was less difficult. She said that this reassured her and therefore she did not weigh Mr A again.

28. Dr B advised Mr A that the blood test results obtained previously were normal. She undertook a cardiovascular disease assessment,[17] which revealed that Mr A was at a 5% risk of cardiovascular attack. She recorded:

> "[Mr A is] [f]eeling better on the omeprazole, still having problems with swallowing but less often, has recent bloods … no [family history] of cardiac problems non smoker no [diabetes] [cardiovascular disease] risk 5% … P[atient]

[12] Fats in the blood.
[13] A cough that lasts eight weeks or longer in adults.
[14] Used to treat symptoms of gastro-oesophageal reflux disease and other conditions caused by excess stomach acid.
[15] Usually used to control symptoms of nausea, vomiting, indigestion or heartburn.
[16] Bacterial infection with symptoms of bloating, belching or burping, nausea, vomiting and abdominal discomfort.
[17] An assessment for people with Type 2 diabetes, which estimates the risk of having a first cardiovascular event (eg, a heart attack or stroke) in the next five years.

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can try lifestyle changes to lower the lipids, repeat bloods in 1 [year] … for review if any ongoing concerns or no improvement."

29. Dr B told HDC: "The plan was for [Mr A] to continue with lifestyle changes … and I asked him to come back if his symptoms continued."

29 April 2014

30. Mr A next consulted Dr B on 29 April 2014. He says that he told Dr B that he had lost more weight (a further six kilograms) and complained of continued difficulty with swallowing and tiredness.

31. Dr B reviewed Mr A's clinical notes dating back over a year, and found that in March 2012 Mr A had weighed 93 kilograms. At this visit, Mr A weighed 78 kilograms. Dr B told HDC that her impression was that the weight loss had been ongoing for over a year as a result of Mr A's deliberate lifestyle changes, and the further weight loss was "not concerning or unexpected".

32. Dr B considered that Mr A needed further investigations, and ordered repeat blood tests, "including CEA[18] and to rule out anaemia, and a chest x-ray to rule out any compression of the oesophagus from a mediastinal mass".[19] In response to the provisional opinion, Dr B told HDC that she did these tests with the intention of referring Mr A.

33. Dr B asked Mr A to return for follow-up to review the test results requested, and she told HDC that there was "a possible plan to refer [Mr A] [for a] gastroscopy[20]".

34. The clinical notes for this consultation include:

"Has been losing weight for two [years]. Initially tried to lose [weight] now continuing to lose [weight]. [Weight] from 93 to 78 today. Epigastric discomfort, feels food hard to swallow, no nausea, no vomiting, bowels regular, feeling tired all the time … E[xperiences]: epigastric tenderness and wakes up at night with it. … [Patient]: for bloods, urine [chest X-ray] [Seen]: [review] with results, for referral for gastroscopy."

35. Mr A's CEA results were received on 30 April 2014, and the result was 6.3ng/ml,[21] which is outside the normal range. Dr B told HDC that her impression at the time was that this rise was "not significant", and that therefore she did not take any further action at that time.

[18] Carcinoembryonic antigen (CEA) is normally present in very low concentrations in the blood but may be elevated in certain types of cancer. A CEA test is a tumour marker that measures the amount of CEA in the blood. CEA may be raised with cancer of the colon, but also in patients with other cancers (lung, breast, liver, pancreas, thyroid, stomach and ovary) or non-cancerous conditions (eg, ulcerative colitis, smoking).

[19] A benign or cancerous growth in the area of the chest that separates the lungs.

[20] Examination of the inside of the oesophagus, stomach, or duodenum (the first part of the small bowel).

[21] The normal range for CEA in an adult non-smoker is 0–4ng/ml.

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8 May 2014

36. Mr A consulted Dr B again on 8 May 2014, and she undertook a further review. Dr B said that Mr A's test results were normal (the repeat blood tests were normal and the chest X-ray showed no mass causing pressure symptoms), and that his symptoms were ongoing but he admitted to not taking his medications regularly.

37. Mr A complained of gastric pain, burping and general discomfort. He also reported that he was still feeling as though food was getting stuck in his oesophagus.

38. Dr B said Mr A reported that he felt that he had put on weight. Dr B did not record Mr A's weight at this consultation, but has accepted that she should have confirmed the reported weight gain. Dr B recorded in the clinical notes:

> "Gastric pain less since has been on omeprazole, uses [as required], gets lots of burping and discomfort, feels like food stuck in the oesophagus and takes time to pass down. Symptoms less now but still persisting. [Patient]: advised to take omeprazole and [M]etamide together, for review 2/12 [in two months' time], may need a referral for gastroscopy if not better next visit, has put on some weight."

39. Dr B said: "[Mr A's weight gain] reassured me … and I decided to give a trial of regular omeprazole before a gastroscopy referral." Dr B also said: "I advised [Mr A] to take [o]meprazole and Metamide together regularly to see if this relieved his symptoms, and to come back for a further review in 2 months' time for a referral for gastroscopy if he was not better." In response to the provisional opinion, Dr B told HDC that a response to omeprazole takes up to two months, which is why she asked Mr A to return for a further review in two months' time (if necessary).

40. Dr B told HDC that she considered a gastroscopy at this stage but was "falsely reassured" by the normal X-ray report and Mr A's haemoglobin level of 161g/L,[22] which was within the normal range.

Gastroscopy referral — Dr C

41. Mr A booked an appointment with Dr C and consulted him on 19 September 2014. He told HDC that he did not return for review earlier because he does not recall being advised to do so by Dr B. He said that had he been told to do so, he would have booked a follow-up consultation at the reception immediately after the consultation, as he had done previously. He stated: "I made all the previous appointments [with Dr B] because I knew something was wrong with me and [I] was keen to find out."

42. Dr C recorded in the clinical notes: "Concerned re weight 92kg to 80kg. Dysphagia[23] [on third] to [half] way down, no reflux. Exam: no nodes, no epigastric pain/tenderness."

43. That day Dr C referred Mr A for an urgent oesophagoscopy[24] and concurrently for a barium swallow.[25] Dr C's referral letter stated, in part:

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[22] The normal range for males is 125–170g/L.
[23] Difficulty swallowing.
[24] Endoscopic examination of the oesophagus.

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"[Mr A] has a six month history of dysphagia which has got progressively worse. It feels as though things are getting stuck between a third and half way down his oesophagus. He said he is having to cut up food very finely and even with this he has to wash it down with fluids … Over the last four to six months he has lost approximately 12 kilograms in weight, going from 92 down to 80 … his liver is not palpable, he has no epigastric tenderness. He has been treated with omeprazole with no improvement. In view of his dysphagia and weight loss I feel he needs reasonably urgent oesophagoscopy…".

44. On 6 October 2014 Mr A underwent an oesophagoscopy, which revealed a signet-ring carcinoma[26] in the lower oesophagus. He was treated with radiotherapy and chemotherapy.

45. Mr A told HDC that he is now very thin and cannot eat as much as he used to, or put on weight.

Further information

Dr B

46. Dr B told HDC that she accepts that it was her responsibility to refer Mr A. She said:

"At all times I was endeavouring to do my best for [Mr A]. The consultations involved much more interaction than just [the] little bit of information recorded in the notes. My thinking at the time (albeit incorrect) was [that] his symptoms were epigastric with reflux … and I therefore managed his symptoms accordingly and considered it was reasonable to defer referral."

47. Dr B recorded the possibility of referring Mr A at the 29 April and 8 May 2014 consultations, but told the Medical Council of New Zealand that she did not refer Mr A for a gastroscopy because he was under the care of another GP at the practice (Dr C) and she expected Mr A to consult with Dr C, who would begin the necessary investigations. However, there is no indication in the clinical notes that she discussed the matter with Dr C or told Mr A to consult Dr C about a referral. Mr A told HDC: "At no stage did [Dr B] ever talk about seeing [Dr C]". Dr B accepts that she should have referred Mr A at the 29 April 2014 consultation. In response to the provisional opinion, Dr B clarified that as Mr A was not her patient, she had no way of knowing who would follow him up, but had noted the possibility of referring [Mr A] as a "pointer as to which direction [her] thoughts were leading to".

48. Dr B told HDC:

"As a result of this case I will ensure that I ask more specific questions regarding those symptoms and monitor more closely with a low threshold for a referral for barium swallow and/or endoscopy. I am also more vigilant about tracking any suspicious findings."

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[25] An X-ray imaging test used to visualise the structures of the oesophagus.
[26] A rare type of cancer found most often in the glandular cells lining the stomach. Under a microscope the cells look like signet rings.

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49. Dr B said that she presented an anonymised version of Mr A's case at a peer review meeting and discussed oesophageal issues with a surgeon at the local hospital. Dr B also said that she has undertaken research on oesophageal cancer and has reviewed online publications on the topic, including from the New Zealand Guidelines Group.

Medical Council of New Zealand

50. The Medical Council of New Zealand told HDC that it is undertaking a performance assessment of Dr B pursuant to section 36 of the Health Practitioners Competence Assurance Act 2003 in respect of the care Dr B provided to Mr A, as detailed in this report.

The medical centre

51. The medical centre provided HDC with a copy of its clinical management guidelines applicable at the time of the events in question. It said that when a new doctor is employed at the practice, he or she is taken through an induction process and given access to all policies and procedures. In addition, its standard operating procedure is reiterated at monthly staff meetings.

52. In response to the provisional opinion, Dr B told HDC that she was not provided with any formal induction process.

Relevant guidelines

53. Relevant guidelines are contained in the New Zealand Guidelines Group publication *Suspected cancer in primary care: guidelines for investigation, referral and reducing ethnic disparities*:[27]

> "a. A person of any age with dyspepsia[28] should be referred urgently for endoscopy or to a specialist if they have any of the following:
>
> - gastrointestinal bleeding
> - dysphagia
> - progressive unexplained weight loss
> - persistent vomiting
> - iron deficiency anaemia
> - epigastric mass
>
> b. A person with dysphagia (specifically, interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process) should be referred urgently."

Response to provisional opinion

Mr A

54. Mr A advised that he did not have any further comment in response to the "information gathered" section of the provisional opinion.

[27] Wellington: New Zealand Guidelines Group (2009).

[28] Indigestion.

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Dr B

55. Dr B's response to the provisional opinion has been incorporated into the report where appropriate. Dr B said that, looking back, she recognises that Mr A's symptoms were pointing to oesophageal cancer, but at the time it was "not so black and white". She said that previously she had not encountered the definition of dysphagia as noted in the guidelines above, and that she "did not appreciate the subtle difference in difficulty swallowing and food getting stuck".

56. Dr B stated:

> "I have carefully read the guidelines on oesophageal cancer and spent much time researching it. I have learned a great deal about the diagnosis of oesophageal cancer and this has completely changed my practice."

57. Regarding the investigation and diagnosis of dysphagia, she stated:

> "As a result of [Mr A's] case I have undertaken a significant amount of research on dysphagia and oesophageal cancer, [and] discussed this case with my peers and specialist colleagues. I am now better informed about dysphagia and have changed my practice since then."

58. Dr B has also completed an annual audit in relation to omeprazole; attended a general practice conference and exhibition; reviewed online materials on oesophageal cancer; reviewed "numerous" relevant articles about endoscopic diagnosis and treatment of oesophageal cancer; discussed oesophageal cancers with hospital surgeons; and discussed cases with other doctors at her practice if they are involved in the care of the same patient.

59. Dr B said that as a result of these initiatives she is now "more alert to the red flag symptoms associated with dysphagia and will ensure that any patients presenting with similar symptoms are immediately referred for endoscopy or barium swallow if their symptoms do not resolve completely".

The medical centre

60. Dr C, on behalf of the medical centre, advised that he did not have any further comment in response to the provisional opinion.

Opinion: Breach — Dr B

61. Mr A presented to Dr B on numerous occasions with "red flags", including weight loss and dysphagia. In my view, there were a number of lost opportunities for Dr B to assess Mr A appropriately and to arrange an urgent referral for an endoscopy on the basis of his ongoing concerning symptoms.

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23 December 2013

62. On 23 December 2013, Mr A presented to Dr B with symptoms of epigastric pain experienced over the preceding month, difficulties swallowing food, and increased wind.

63. Mr A told Dr B that he had been losing weight, and was having difficulty swallowing and trouble eating.

64. Dr B told HDC that she understood that Mr A had been losing weight as a result of lifestyle changes, and that these changes were being overseen by Dr C. Dr B said her impression was that Mr A's weight loss had been gradual and was not progressive. As such, she did not consider it to be unexplained. She recorded in the clinical notes that Mr A had not been trying to lose weight and that he weighed 84 kilograms, but did not establish how much weight Mr A had lost. Dr B told HDC that she was unaware of the extent of Mr A's weight loss and did not review the notes "as far back as a year" because Mr A's symptoms had been present for only one month. Dr B said that she was not aware that Mr A had weighed 93 kilograms in 2012.

65. Dr B examined Mr A and found no abnormality in his abdomen. Dr B's working diagnosis was gastritis. She prescribed Mr A omeprazole 40mg and Metamide 10mg, and arranged blood tests including a full blood count and a test to rule out *Helicobactor pylori*. The blood test results received the following day were normal.

66. My clinical advisor, GP Dr David Maplesden, advised me that there were sufficient "red flags", namely recent onset dysphagia and unexplained weight loss, evident at this initial consultation to make an urgent referral for endoscopy a prime consideration.

67. I acknowledge Dr B's statement that she was not aware of the extent of Mr A's weight loss, and that she considered that this had been a result of lifestyle changes being overseen by Dr C. However, I note that Mr A had not been trying to lose weight, which Dr B was aware of and recorded in the clinical notes. Accordingly, I consider that in the circumstances the weight loss was unexplained. I am also critical that Dr B did not establish how much weight Mr A had lost by reviewing the clinical notes.

68. Dr Maplesden advised that it was reasonable for Dr B to commence symptomatic treatment[29] and to investigate for iron deficiency anaemia and *Helicobactor pylori* status while awaiting the investigation, but these actions should not have precluded or delayed the endoscopy referral, irrespective of the results of the investigations or Mr A's response to treatment.

69. I accept Dr Maplesden's advice. I consider that this was the first lost opportunity to assess Mr A appropriately and arrange an urgent referral on the basis of his symptoms.

[29] Therapy to ease symptoms, not the cause of a disease.

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3 February 2014

70. Mr A consulted Dr B again on 3 February 2014 for review, and complained of ongoing (but reduced) difficulty with swallowing.

71. Dr B recorded that Mr A was "feeling better on the omeprazole". A weight measurement was not repeated, and therefore progression of weight loss was not ascertained. Dr B's plan was for Mr A "to continue with lifestyle changes", and he was asked to return if his symptoms continued.

72. Dr Maplesden advised that at this consultation there remained an indication for urgent referral for endoscopy. I accept this advice. In my view, as Mr A's symptoms were ongoing, again Dr B should have recognised the need to make an appropriate referral. I am also critical that Dr B did not weigh Mr A at this consultation.

29 April 2014

73. Dr B next reviewed Mr A on 29 April 2014. Mr A told Dr B that he had lost more weight, and had continued difficulty swallowing and tiredness.

74. Dr B reviewed the clinical notes and noted for the first time that, in 2012, Mr A had weighed 93 kilograms. Her clinical notes for this consultation record that Mr A had been losing weight for two years, and that while he had initially tried to lose weight, he was now continuing to lose weight. Dr B's impression was that the weight loss was a result of deliberate lifestyle changes. Dr B requested repeat blood tests (including for CEA and anaemia) and a chest X-ray, and made a "possible plan" to refer Mr A for a gastroscopy. Dr B told HDC that these tests were undertaken with the intention of referring Mr A.

75. Dr Maplesden noted that by the 29 April 2014 consultation, there were very clear indications for urgent referral for gastroscopy, based on Mr A's age and history of progressive unexplained weight loss and persistent dysphagia. Dr Maplesden said that the clinical rationale for choosing a chest X-ray over an endoscopy as an investigative priority in this clinical scenario is difficult to justify. Dr Maplesden also advised that it was inappropriate to order CEA as a diagnostic or screening test in this clinical scenario.

76. I agree with this advice, and note that Dr B accepts that she should have referred Mr A at this consultation. In my view, Mr A's presenting symptoms warranted an urgent referral for gastroscopy. I am critical that, instead, Dr B elected other investigations as priorities.

77. Mr A's chest X-ray showed no abnormalities, and his blood test results were normal except for the CEA result, which was raised at 6.3ng/ml. Dr B said that her impression was that this rise was "not significant", and that therefore she did not take any further action at that time. Dr Maplesden advised that this result was abnormal. I accept this advice, and am critical that Dr B chose not to take any further action in this regard.

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8 May 2014

78. Mr A was reviewed again by Dr B on 8 May 2014. He told Dr B that he felt that he had put on some weight, but he complained of gastric pain, burping, general discomfort and continued difficulty swallowing. Dr B did not weigh Mr A, nor did she record his self-assessed weight. She accepts that she should have confirmed the weight gain.

79. Dr B recorded that Mr A experienced less gastric pain when he used omeprazole, but that he still experienced burping, discomfort and continuing dysphagia. She advised Mr A to take omeprazole and Metamide together regularly, and to return for further review in two months' time if he was not feeling better. Although this is recorded in the clinical notes, I note that there is disagreement as to whether Mr A was advised to return in two months' time.

80. In any event, Dr Maplesden advised me that at that appointment: "There remained an indication for urgent referral for a gastroscopy irrespective of whether [Mr A's] weight had stabilised." I accept that advice, and am critical that, again, Dr B did not complete a referral. I am also critical that Dr B again failed to weigh Mr A.

81. Dr Maplesden advised that Dr B's management of Mr A during the period she provided care to him was "seriously deficient". Dr Maplesden stated that aspects of Dr B's management of Mr A, namely the failure to refer him urgently in light of his recent onset of dysphagia and unexplained weight loss, and instead to undertake investigations that were less appropriate, represented a severe departure from expected standards. Dr Maplesden advised:

> "At each of the consultations [Dr B] undertook with [Mr A] over a period of six months there were obvious clinical indications for urgent referral of the patient for further investigation to exclude oesophageal cancer as a cause of his new onset upper GI symptoms, particularly his dysphagia, associated with unexplained weight loss. While [Dr B] appears to have noted this from time to time, no such referral was made but less appropriate investigations were given priority."

Conclusion

82. Mr A consulted Dr B on four occasions over approximately six months. The evidence indicates that, from the first consultation and to varying degrees throughout that period, Mr A presented to Dr B with "red flags", including unexplained weight loss and dysphagia. Despite being responsible for arranging the necessary investigations based on the information presented during the extended period she was consulted, Dr B did not assess Mr A appropriately, and did not arrange for him to be referred for an endoscopy urgently.

83. In my view, by failing to assess Mr A appropriately and arrange for him to be referred urgently for an endoscopy on 23 December 2013, 3 February 2014, 29 April 2014 and 8 May 2014, Dr B failed to provide services to Mr A with reasonable care and skill. Accordingly, Dr B breached Right 4(1) of the Code.

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Opinion: No Breach — The medical centre

84. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), employing authorities are vicariously liable for any breach of the Code by an employee. Under section 72(5) of the Act, an employer is liable for acts or omissions by an employee unless the employer proves that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

85. During the period under investigation, Dr B was an employee of the medical centre.

86. Dr Maplesden reviewed the medical centre's orientation process for new doctors, access to educational material within the medical centre, and its Clinical Management Guidelines. He advised that this information was consistent with accepted standards. Dr Maplesden had no concerns with the level of professional support offered to Dr B by the medical centre.

87. I am satisfied that the Clinical Management Guidelines and employee orientation and support mechanisms were adequate, and although Dr B says that she was not provided with a formal induction process, I consider that the failure to assess Mr A appropriately and refer him for an endoscopy was Dr B's alone. Accordingly, I do not find the medical centre vicariously liable for Dr B's breach of the Code. Neither do I consider that the medical centre is directly liable in this case.

Recommendations

88. I recommend that Dr B:

a) Provide a written apology to Mr A for the failures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Undertake appropriate training in the use of CEA tumour marker tests, in conjunction with the Royal New Zealand College of General Practitioners, and provide evidence to HDC of having completed the training, within three months of the date of this report.

c) Arrange for an independent general practitioner peer to conduct:

i. a qualitative review of a random selection of 30 patients' consultation notes that Dr B has completed within the last 12 months, to determine whether appropriate assessment and review has occurred in response to presenting symptoms; and

ii. a random audit of 10 referrals to specialist secondary services that Dr B has instigated within the last 12 months, to check that appropriately documented

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requests have been performed and appropriate reminders have been put in place to follow up such referrals.

89. Dr B should provide a copy of the above review and audit to HDC within three months of the date of this report.

Follow-up actions

90. Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether proceedings should be taken.

91. An anonymised 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 relevant district health board, and they will be advised of Dr B's name in covering correspondence.

92. An anonymised 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.

Addendum

93. The Director of Proceedings brought disciplinary proceedings against Dr B in the Health Practitioners Disciplinary Tribunal which resulted in a finding of professional misconduct. Dr B appealed the Tribunal's finding of professional misconduct in the High Court. The High Court dismissed Dr B's appeal and upheld the Tribunal's decision. The Director did not take HRRT proceedings against Dr B.

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Appendix A: In-house clinical advice to the Commissioner

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

"1. My name is David Maplesden. I am a vocationally registered general practitioner practising in Hamilton, New Zealand. My qualifications are MB ChB (Auckland University 1983), Dip Obst (1984), FRNZCGP (2003). I have provided advice for the Health and Disability Commissioner as in-house clinical advisor (part-time) since 2009. I have read the Code of Conduct for expert witnesses and agree to abide by this Code. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Mr A]; response from [Dr B]; GP notes ([the medical centre]) including copies of relevant specialist reports.

2. [Mr A] complains about delays in the diagnosis of his oesophageal cancer. On 22 September 2014 he was referred for gastroscopy by his regular GP, [Dr C], for symptoms of weight loss and dysphagia for which he had seen, and been treated by, [Dr B] since the end of 2013. He underwent gastroscopy on 6 October 2014 and this showed an oesophageal cancer confirmed on histopathology as a signet-ring carcinoma. This was staged as T3N0/IIIA and was felt likely to have progressed over the nine months between [Mr A] first presenting his symptoms to [Dr B] and his eventual referral for endoscopy. [Mr A] feels his cancer should have been diagnosed earlier than it was.

3. [Dr B] notes [Mr A] was not her regular patient but she saw him on several occasions from December 2013. She notes his weight in March 2012 had been 92kg and he had been losing weight for some time since making lifestyle changes to lower his lipid levels. Because of this, she did not regard the weight loss observed on 23 December 2013 as necessarily being unexplained and was reassured on that date by the absence of other 'classical' symptoms for oesophageal cancer (which she lists) and subsequently by the improvement in [Mr A's] symptoms on omeprazole. When symptoms were persisting and there had been further weight loss in April 2014 [Dr B] considered further investigations were required and ordered tumour markers (CEA) and chest X-ray neither of which were diagnostic. She was reassured by the absence of anaemia. At her final review of [Mr A] on 8 May 2014 his symptoms were perhaps improved and he felt he may have gained a little weight. She states she advised [Mr A] to continue with his regular medications and to *come back for review in two months' time for a referral for gastroscopy if he was not better.* Since being made aware of this case [Dr B] has researched oesophageal cancer and dysphagia symptom in some detail and has presented the case (anonymized) to her peer group. She has made alterations to her practice to ensure any symptom suggestive of dysphagia mentioned by a patient is clarified and promptly investigated in the future.

4. The standards/recommendations I have referred to in this advice are:

(i) New Zealand Guidelines Group. Suspected cancer in primary care: guidelines for investigation, referral and reducing ethnic disparities. Wellington: New

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Zealand Guidelines Group; 2009. Relevant extracts in relation to oesophageal or gastric cancer being:

a. A person of any age with dyspepsia should be referred urgently for endoscopy or to a specialist if they have any of the following:

• gastrointestinal bleeding

• dysphagia

• progressive unexplained weight loss

• persistent vomiting

• iron deficiency anaemia

• epigastric mass

b. A person with dysphagia (specifically, interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process) should be referred urgently.

c. For a person with unexplained weight loss or iron deficiency anaemia, without dyspepsia, the possibility of upper gastrointestinal cancer and need for urgent referral for investigation should be considered.

(ii) Gastroenterological Society of Australia (GESA). Reflux disease: Gastro-oesophageal reflux disease in adults. Victoria: GESA 2011[1]. Summary includes:

a. The complications of GORD are more likely in patients with red flags; these patients should be referred promptly for endoscopy. Empirical treatment with a PPI can be initiated for symptom control but should not delay the timing of referral.

b. Red flags for patients with GORD requiring endoscopy include:

Dysphagia (difficulty with swallowing); which may be caused by inflammation, abnormal peristalsis or oesophageal hypersensitivity. If dysphagia and globus pharyngeus (the sensation of a 'lump in the throat') are present then peptic stricture should be suspected.

Odynophagia (pain with swallowing), which is generally associated with severe oesophagitis.

Haematemesis.

Weight loss with no obvious explanation.

Patients aged 55 years or older with unexplained and persistent dyspepsia of recent onset; these patients are at increased risk of gastric and oesophageal cancer.

5. Historical GP notes suggest [Mr A] was a moderate smoker (10/day) in 2004 but from 28 March 2012 and subsequently he is recorded as a non-smoker.

[1] www.gesa.org.au/files/editor_upload/File/Professional/Reflux_Disease.pdf Accessed 2 September 2015

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Alcohol intake is recorded as *beer, few pints/week* in 2004. No other relevant past medical or family history is noted although [Dr B] has stated [Mr A's] weight in March 2012 was 92kg. [Dr B] first reviewed [Mr A] on 23 December 2013. Notes include:

Has epigastric pain for a month, has not been trying to lose weight, feels like food will not go down, dull ache in the middle of the night, no heartburn, more wind, no nausea, no vomiting, bowels normal. E: has epigastric tenderness afebrile lower abdomen [sic] *A: Gastritis r/o helicobacter … R/V with results, may need further investigations.*[Dr B] prescribed [Mr A] metoclopramide 10mg TDS x90 tabs and omeprazole 40mg OD x90 caps. Blood tests were ordered (No anaemia, H pylori serology negative, liver function essentially normal, CRP minimally raised at 5.8 mg/L (normal <5)). Weight was recorded as 84kg (loss of 8kg since March 2012) and BMI was calculated as 25.6.

Comment: [Mr A] was a 57 year old gentleman with new onset of upper GI symptoms including dysphagia, epigastric pain, retrosternal ache (as clarified by [Dr B] in her response) and belching. He had had an 8kg weight loss and it is not clear whether this was gradual or more recent and rapid. Contrary to the implication in [Dr B's] response that the weight loss was a result of deliberate lifestyle changes, it is documented that [Mr A] had not been trying to lose weight therefore I would regard the weight loss as being unexplained. I think there were sufficient 'red flags' evident in this consultation to make urgent referral for endoscopy a prime consideration and [Dr B] failed to do this. It was reasonable to commence symptomatic treatment and to investigate for iron deficiency anaemia and H pylori status while awaiting the investigation, but these actions should not have precluded or delayed the endoscopy referral irrespective of the investigations results or response to treatment.

6. [Dr B] reviewed [Mr A] on 3 February 2014. She noted: *feeling better on the omeprazole, still having problems with swallowing but less often …* a cardiovascular risk assessment was performed (estimated 5-year risk 5%). Documented management plan was: *can try life style changes to lower the lipids, repeat bloods in 1 yr … for review if any ongoing concerns or no improvement.* Weight measurement was not repeated on this occasion.

Comment: [Mr A's] symptom of dysphagia was persisting albeit somewhat improved from previously. Progression of weight loss was not ascertained. I believe there remained an indication for urgent referral for endoscopy at this point.

7. [Dr B] next reviewed [Mr A] on 29 April 2014. Notes include:

Has been losing weight for 2 yrs. Initially tried to lose wt now continuing to lose wt. Wt from 93 to 78 today. Epigastric discomfort, feels food hard to swallow, no nausea, no vomiting, bowels regular, feeling tired all the time … E: epigastric tenderness and wakes up at night with it. Drinks 2 jugs in a session weekly socially, also drinks a lot of coffee, non-smoker P: for bloods, urine CXR. S: RV with results, for referral for gastroscopy.

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[Mr A] underwent chest X-ray on 30 April 2014 and this was reported as normal. Clinical indication was recorded as: *Losing wt difficulty in swallowing, feels food stuck retrosternally.* Blood tests showed no evidence of anaemia or iron deficiency, liver function remained normal and CRP was just over upper limit of normal. The tumour marker CEA had been ordered and was raised at 6.3 ng/ml (reference range 0.0–4.0 with pathologist comment *Results for otherwise healthy smokers may be raised as high as 10 ng.ml*). I note [Mr A] was not a smoker at this stage. On 30 April 2014 [Dr B] faxed [Mr A] a prescription for a further 90x40mg omeprazole to be taken once daily. No referral was made for gastroscopy.

Comment: There were very clear indications for urgent referral for gastroscopy based on [Mr A's] age and history of progressive unexplained weight loss and persistent dysphagia. The clinical rationale for choosing chest X-ray over endoscopy as an investigation priority in this clinical scenario is difficult to justify. It was inappropriate to order CEA (or other tumour markers) as a diagnostic or screening test for malignancy in this clinical scenario[2], and in any case the abnormal (although likely irrelevant) result appears to have been ignored (noting [Mr A] was not a smoker).

8. [Dr B] undertook her final review of [Mr A] on 8 May 2014. Notes include: *gastric pain less since has been on omeprazole, uses PRN, gets lots of burping and discomfort, feels like food stuck in the oesophagus and takes time to pass down. Symptoms less now but still persisting. P: advised to take omeprazole and metamide together, for review 2/12, may need a referral for gastroscopy if not better next visit, has put on some weight* [patient not weighed on this occasion].

Comment: [Mr A's] upper GI symptoms, including dysphagia, were persisting. There remained an indication for urgent referral for gastroscopy irrespective of whether his weight had stabilized.

9. [Mr A] next attended [Dr C] on 19 September 2014. Notes include: *concerned re weight 92kg to 80kg. Dysphagia 1/3 to 1/2 way down, no reflux. Exam: no nodes, no epigastric pain/tenderness.* [Mr A] was referred the same day for urgent endoscopy and concurrently for barium swallow — this to be cancelled if endoscopy was undertaken first (as did occur). The referral letter included: [Mr A] *has a six month history of dysphagia which has got progressively worse. It feels as though things are getting stuck between a third and half way down his oesophagus. He said he is having to cut up food very finely and even with this he has to wash it down with fluids … Over the last four to six months he has lost approximately 12 kilograms in weight, going from 92 down to 80 … his liver is not palpable, he has no epigastric tenderness. He has been treated with omeprazole with no improvement. In view of his dysphagia and weight loss I feel he needs reasonably urgent oesophagoscopy …*

Comment: [Dr C's] management of [Mr A] was clinically appropriate.

[2] See http://www.bpac.org.nz/BT/2010/July/tumour-markers.aspx. Accessed 2 September 2015

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10. Final comment: I feel [Dr B's] management of [Mr A] was seriously deficient and would be met with severe disapproval by my peers. At each of the consultations she undertook with [Mr A] over a period of six months there were obvious clinical indications for urgent referral of the patient for further investigation to exclude oesophageal cancer as a cause of his new onset upper GI symptoms, particularly his dysphagia, associated with unexplained weight loss. While [Dr B] appears to have noted this from time to time, no such referral was made but less appropriate investigations were given priority. I think this case might raise come concerns regarding [Dr B's] competency and recommend a referral to the Medical Council of New Zealand."

The following additional advice was sought from Dr Maplesden:

"I have reviewed additional information received since providing my original advice dated 2 September 2015.

1. Letter from [Dr C] dated 19 November 2015

[Dr C] discusses the orientation and professional support provided to new doctors joining his practice and relevant practice policy documents were provided. The orientation process appears consistent with accepted practice and I note the relevant employment contract included standard provisions for annual leave (which the employee was encouraged to take regularly) and for pain conference leave. There was good access to educational material within the practice via access to Map of Medicine, and there was a regular scheduled staff meeting. I note [Dr B] had many years of general practice experience and had been awarded FRNZCGP prior to the events in question. There are minimum requirements for ongoing professional development and education set by both the MCNZ and RNZCGP which I presume [Dr B] was fulfilling. I have no concerns with the professional support offered to [Dr B] by her employer.

2. Letter from [Dr B] dated 2 December 2015

(i) [Dr B] has not presented any new factual information regarding her consultations with [Mr A]. She reiterates her impression that [Mr A's] weight loss was gradual and intentional and was never 'unexplained'. However, I note again that she recorded at her initial consultation with [Mr A] on 23 December 2013 that he *has not been trying to lose weight* which she states [Mr A] told her, implying there had been unintentional weight loss (which there had) although [Dr B] did not establish at this appointment the degree of weight loss. When [Dr B] finally established the degree of weight loss at an appointment on 29 April 2014 (from 93kg in March 2012, 84kg December 2013, 78kg April 2014) she noted [Mr A] *Initially tried to lose weight now continuing to lose wt* again implying the ongoing weight loss was unintentional. Unexplained weight loss was a red flag in the clinical scenario presented, but even if [Dr B] had misperceived the nature of the weight loss there was still the red flag of dysphagia evident as a presenting symptom in December 2013, and persisting to varying degrees (but never disappearing) at subsequent consultations [Dr B] had with [Mr A] over the next six months, which necessitated urgent referral for endoscopy.

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(ii) [Dr B] has concerns that my original advice is likely to give a third party reading the advice *an impression that I was uncaring and deliberately decided not to act on the symptoms exhibited by [Mr A] when he presented for consultations.* I acknowledge that it is not possible to determine from contemporaneous clinical documentation the subtleties and complexities of the patient–doctor interaction and I do not wish to give any impression that [Dr B] was uncaring in her approach. I do not feel my original advice implies there was any deliberate act of omission on [Dr B's] part, but I remain strongly of the view that, for whatever reason, there were deficiencies in [Dr B's] management of [Mr A] that were serious in nature and were significant departures from recommended and accepted practice with respect to the clinical scenario described. As such, I maintain my view that there were aspects of [Dr B's] management of [Mr A] that represent a severe departure from expected standards.

(iii) Since the events in question [Dr B] has undertaken significant education on the investigation and management of patients with upper GI symptoms and she should be commended on the conscientious approach she has taken in this regard."

The following further advice was received from Dr Maplesden:

"The 'red flags' indicating need for urgent referral (as per guidelines in force at the time of the events in question) were recent onset dysphagia and unexplained weight loss which were present from the time of the first consultation discussed in my advice. The severity of the departure was compounded by the fact the consumer made repeated visits over several months with these symptoms persisting and still no appropriate referral was made. Instead less appropriate investigations were undertaken (that also being a compounding factor but looked at in isolation (which I do not believe it is appropriate to do) not a severe departure from expected standards in itself). I would have been somewhat less critical (although still critical) if, say, the patient had been reviewed after a month of treatment and then referred when the symptoms persisted."

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