General Practitioner, Dr A

Medical Centre

Waitemata District Health Board

A Report by the

Health and Disability Commissioner

(Case 13HDC00926)

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Executive summary

1. On 20 April 2012, Mr C visited GP Dr A at a medical centre. Mr C reported going to the toilet as much as 40 times a day, and had weight loss and rectal bleeding. Dr A's differential diagnoses included irritable bowel syndrome (IBS) and carcinoma. Dr A requested blood investigations. Follow-up review was recorded "as needed". Dr A instigated a referral to Waitemata DHB (the DHB) Gastroenterology Outpatients for specialist assessment.

2. The 20 April referral went through a usual medical practice administration process and, according to the medical centre, was faxed to the DHB. However, the DHB said that the referral was not received.

3. Under the guideline in place at the medical centre, it was left to individual doctors to set electronic reminders for following up referral letters. These reminders were not automatically generated. Dr A did not use his Medtech patient information system to set a reminder to follow up the referral. Dr A did not give Mr C information about an expected timeframe for the specialist appointment, or what to do if he had not received an appointment time or if his symptoms worsened.

4. On 24 April, Mr C went to the Emergency Department (ED) at the public hospital with a painless right groin swelling. ED specialist Dr E obtained a different history from that obtained by Dr A. Dr E considered that Mr C had an inguinal hernia, and instigated a referral to the general surgical team.

5. On 10 May, the DHB sent an electronic receipt message to Dr A advising that a referral to the surgical team (Dr E's referral), received 26 April, had been declined owing to waiting list management. Dr A (incorrectly) believed that this message related to his gastroenterology referral of 20 April. Dr A also noted that there was an absence of persisting significant symptoms on the 24 April ED discharge summary.

6. Mr C did not return to the medical centre for review until 2 July 2012. He saw locum Dr D with continuing symptoms. Dr D noticed the initial 20 April referral, checked with the DHB, which confirmed that the referral had not been received, discussed this with Dr A, and instigated a re-referral to Gastroenterology Outpatients.

7. On 29 July, the DHB sent an electronic receipt message to Dr A advising that the referral to Gastroenterology Outpatients, received by the DHB on 3 July, had been assigned a P2 priority — to be seen within six weeks. The waiting time for the appointment was deemed "unknown". The DHB had taken 26 days to triage, grade, and communicate a decision back to the referrer. The DHB said that expected waiting times were noted as "unknown" because of long waiting lists, and it had been unable to provide GPs and patients with a time in which the patient would be seen.

8. The DHB provided HDC with a copy of its then standard referral waiting list acknowledgement letter to patients. That letter advises a patient that a referral has been graded by a specialist and has been accepted, and that the patient will receive an appointment "in due course". It also advises that if any change in condition is experienced, the patient should contact his or her GP, who, it advises, can request review of the referral. It is not known whether Mr C received that letter.

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9. On 17 August, Mr C presented to the medical centre and was seen by a locum doctor, who was aware that Mr C was waiting for an appointment for a gastroenterology review. On 11 September 2012, Mr C presented to the public hospital ED with blood in his urine. The ED specialist reviewing him suspected rectal cancer, and transferred Mr C to another hospital. Tests revealed advanced metastatic carcinoma of the rectum. Mr C later died in hospice care.

Findings summary

10. Although Dr A did turn his mind to more sinister pathology, there was criticism of him for not classifying his referral of 20 April 2012 as urgent. Dr A did not provide Mr C with scheduled follow-up or appropriate information and advice relating to action Mr C should take if his symptoms persisted, and failed to instigate a precautionary electronic reminder to follow up the gastroenterology referral. Dr A also failed to identify accurately that the decline message he received on 10 May related to a general surgical referral on a different date, did not contact Mr C to check on his symptoms, and did not advocate effectively for his patient by contacting the DHB to query its 10 May decline message.

11. Accordingly, Dr A did not provide services to Mr C with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

12. While there was concern that the processes in place at the medical centre at the time did not include a mandatory automatic reminder system, or retention of hard copy records of fax transmissions beyond three months, it is noted that the medical centre has made changes to its DHB referral systems that are in line with the accepted standard today.

13. Waitemata DHB's turnaround time and the delays experienced in relation to its processing of Dr A's referral of Mr C to Gastroenterology Services were substandard.

14. This report highlights the importance of the provision of clear and timely information. Although Waitemata DHB provided electronic messages to Dr A regarding the status of referrals to its specialist services, it was unable to provide any clear information to Dr A about the estimated timeframe in which specialist gastroenterology assessment/investigation would occur. Waitemata DHB did not provide Mr C with clear information about an estimated timeframe for a specialist assessment. Accordingly, the DHB breached Right 6(1)(c) of the Code.[2]

15. In response to my provisional opinion, Waitemata DHB made changes to its referral waiting list acknowledgement letter. It provided an example of the Gastroenterology Department's revised letter for this grading. It advised the patient that "We have received a referral from your doctor requesting a Gastroenterology procedure. Your

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

[2] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances would expect to receive, including — (c) Advice of the estimated time within which the services will be provided."

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referral has been graded by a specialist and has been accepted. The current maximum waiting time is four (4) months. You may receive an appointment before this, if we are able to offer an earlier date." The letter concludes that if the patient experiences any change in their condition, or has any concerns, they should contact their general practitioner.

16. The DHB is criticised for being unable to provide clarity about the identity of the clinician grading the 2 July gastroenterology referral such that would allow for purposeful quality assurance activities and/or audit.

Complaint and investigation

17. The Commissioner received a complaint from Ms B about the services provided to her father, Mr C. The following issues were identified for investigation:

- *Whether the medical centre provided care of an appropriate standard to Mr C between 2011 and 2013.*
- *Whether Waitemata District Health Board provided care of an appropriate standard to Mr C between 2011 and 2013.*
- *Whether Dr A provided care of an appropriate standard to Mr C between 2011 and 2013.*

18. The main parties referred to in the report are:

Dr A	General practitioner[3] the medical centre
Ms B	Complainant, Mr C's daughter
Mr C (dec)	Consumer
Medical centre	Provider
Dr D	General practitioner
Dr E	ED consultant, Waitemata DHB
Waitemata District Health Board	Provider

19. Information was also provided by the Royal New Zealand College of General Practitioners.

20. Clinical advice was provided by in-house clinical advisor Dr David Maplesden (**Appendix A**).

[3] Dr A is a Fellow of the Royal New Zealand College of General Practitioners. He obtained vocational scope in general practice in 2011. He worked as a long-term independent contracting locum and worked at several practices on an as-needed basis until he became based at the medical centre.

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Information gathered during investigation

Background

21. On 5 October 2011, Mr C, aged 52 years, enrolled with the medical centre. Mr C had four separate consultations at the medical centre between 22 November 2011 and 17 August 2012.

The medical centre

22. The medical centre has three full-time general practitioners. No appointments are required for patients. When a doctor is on leave, a locum doctor provides cover. Locums are familiar with the systems and guidelines at the medical centre. The medical centre uses the electronic patient management system (PMS) MedTech. All the doctors providing care to Mr C in this case are vocationally registered GPs. The medical centre is Cornerstone accredited by the Royal New Zealand College of General Practitioners (RNZCGP).[4]

22 November 2011 visit to the medical centre

23. On 22 November 2011, Mr C went to the medical centre and was first seen by a nurse as a new patient. It is recorded that Mr C reported having haemorrhoids, and some constipation that had been resolved by diet, and that he was keen to stop smoking. His weight was recorded as 68kg. Weight loss was not reported. Baseline observations were taken.

24. Mr C was then seen by a locum. Mr C reported a six-month history of intermittent rectal bleeding with a reducible anal lump. At the time, the history and physical examination (abdominal and rectal) findings were felt to be consistent with haemorrhoids. No weight loss or alteration in bowel habit were reported. Mr C was prescribed medication for the haemorrhoids and encouraged to return for review.

20 April 2012 visit to the medical centre — Dr A

25. At his second consultation on 20 April 2012, Mr C saw Dr A, a full-time medical centre GP. Mr C told Dr A that before attending the medical centre in November he had not been to a doctor for about 20 years. Mr C complained of a number of symptoms, including altered bowel habit, going to the toilet as much as 40 times a day, unintentional weight loss, and PR[5] mucus/bleeding. The duration of these symptoms was not recorded. There was no abdominal pain, and no abnormality noted on examination of the rectum. Mr C's weight, or the degree of weight loss reported, was not recorded.

26. On 20 April 2012, Dr A documented:

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[4] Cornerstone is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand. Accreditation is a self-assessment and external peer review process used by healthcare organisations to assess their level of performance accurately in relation to established standards, and to implement ways to continuously improve the healthcare system.

[5] Per rectum.

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"Never see GP may be in last 20 yrs recently altered bowel habit may be going 40 times to toilet daily with passage of mucus and bloods even during night as well lost significant amount of weight as well … very stressed and can't work for repeated toilet visits … [digital rectal examination]: mild relaxed anus rectum full of stool …"

27. Dr A's differential diagnoses included inflammatory bowel disease, infectious colitis,[6] irritable bowel syndrome (IBS),[7] and carcinoma.

28. Dr A requested blood investigations, including a full blood count, ESR test,[8] liver function, C-reactive protein (CRP) test,[9] serum calcium and phosphate, renal function, lipids, thyroid function, iron studies, a PSA test,[10] serum B_{12} and folate, diabetic profile, coeliac antibodies,[11] faecal cultures, and faecal occult bloods.

29. Dr A told HDC: "[M]y basis for considering IBS as a differential diagnosis was that [Mr C's] presenting symptoms were not consistent with my exam findings and that I was seeing him for the first time. Although a sinister cause was in my mind, I put a working differential diagnosis and treated [Mr C] for this as well as making a referral."

30. An anti-spasmodic and a bulking agent were provided as treatment. Follow-up was recorded as "[review] as needed", and no follow-up was scheduled.

Referral to Gastroenterology

31. Following the consultation on 20 April 2012, Dr A referred Mr C to Waitemata DHB Gastroenterology Outpatients (the public hospital) for specialist assessment.

32. Dr A's notes record:

"20 April 2012: Outbox: Clinic/Hosp referral, Gastro-enterology Registrar"

and

"To Gastroenterology Registrar/[outpatient clinic]. Thank you for seeing my patient and advising on how we can improve their care, Reason for Referral: to exclude any sinister bowel disease."

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[6] Inflammation of the colon.

[7] Irritable bowel syndrome (IBS) is a common disorder that affects the large intestine (colon). Irritable bowel syndrome commonly causes cramping, abdominal pain, bloating, gas, diarrhoea and constipation.

[8] The erythrocyte sedimentation rate (ESR) is a non-specific test (measuring the rate at which red blood cells settle) to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.

[9] A protein produced by the liver. Levels rise in response to inflammation.

[10] Prostate Specific Antigen Test (PSA).

[11] Coeliac disease antibody tests are primarily used to help diagnose and monitor coeliac disease, an autoimmune disorder.

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National referral guidelines — primary care

33. The relevant national guidelines at the time[12] included the following recommendations in relation to primary care clinicians acting on suspicion of colorectal cancer:

> "…
>
> A person aged 40 years and older reporting rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting for 6 weeks or more should be referred urgently to a specialist.
>
> …
>
> A person presenting with a palpable rectal mass (intraluminal and not pelvic), should be referred urgently to a specialist, irrespective of age.
>
> A man of any age with unexplained iron deficiency anaemia and a haemoglobin of 110 g/L or below, should be referred urgently to a specialist.
>
> …
>
> A person presenting with a right-sided abdominal mass, should be referred urgently for a surgical opinion.
>
> …
>
> For a person with equivocal symptoms, a complete blood count may help in identifying the possibility of colorectal cancer by demonstrating iron deficiency anaemia. This should determine if a referral is needed and whether the person should be urgently referred to a specialist.
>
> For a person where the decision to refer to a specialist has been made, a complete blood count may be considered to assist specialist assessment in the outpatient clinic.
>
> For a person where the decision to refer to a specialist has been made, no examinations or investigations other than an abdominal and rectal examination, and a complete blood count should be undertaken as this may delay referral.
>
> A person at low risk of colorectal cancer with a significant symptom (rectal bleeding or a change in bowel habit) and a normal rectal examination, no anaemia and no abdominal mass, should be managed by a strategy of treat, watch and review in three months.
>
> …
>
> Faecal occult blood and carcinogenic embryonic antigen testing are of little value in a person with symptoms suggestive of colorectal cancer and should not be used.
>
> …"

[12] See: New Zealand Guidelines Group, *Suspected cancer in primary care: guidelines for investigation, referral and reducing ethnic disparities*. Wellington: New Zealand Guidelines Group; 2009, p43–44.

HDC

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Faxed referral, 20 April

34. Dr A's referral on 20 April 2012 included a copy of his consultation notes. Dr A did not give Mr C information about an expected timeframe for the specialist appointment, or what to do if he did not receive an appointment time or if his symptoms worsened.

35. Dr A told HDC that he is confident that the referral was sent. He said that he followed his usual process and that of the clinic.

36. He said that he printed out the referral letter and placed it in a cubby hole designated for referrals to be sent by fax. Reception staff then sent the referrals by fax. Each day the referrals were removed from the cubby hole only when they were to be sent. Confirmation was then obtained that the fax had reached its destination, and the document was stamped as sent. Hard copy of the referral was retained for three months.

37. Computerised copies of referrals routinely remained in the patient record, but did not have the fax number or confirmation stamped on them.

38. The medical centre provided a screenshot of the MedTech system's address book listings used in 2012 for the referral, which include the correct number listed for the public hospital Outpatients Clinic.

39. However, as the medical centre retained only hard copy confirmation fax printouts for three months before destroying them, there is now no record to confirm whether the faxed referral in question was sent from the medical centre.

40. The DHB told HDC that there is no record of receipt of a referral from Dr A to Gastroenterology Outpatients dated 20 April 2012 or any other date.

41. Dr A did not use his MedTech practice management system to set a reminder to follow up on his referral.

Medical centre referral follow-up guidelines

42. The medical centre provided HDC with a copy of the applicable guideline in place at the time — "Guideline for the management of inbox records and outbox requests".[13]

43. It was left to individual doctors to set electronic reminders for following up referral letters. These reminders were not generated automatically.

44. The guideline states:

> "**OUTBOX REQUESTS (including lab requests and referrals)**
> The requesting clinician can ensure all lab requests and referral letters can be followed-up by sending a patient-staff task to themselves, or their deputy if going

[13] Version 2002:5. Approved May 2002. Page 2.

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on leave, by going to the 'More' tab of the outbox document and completing the appropriate fields, including the task reminder date …"

45. In addition, the guideline sets out that it is the responsibility of each doctor to check daily all abnormal results.[14] In relation to action and notification, the guideline states: "Upon receipt of the inbox record the doctor can track important results or correspondence by assigning a patient recall or other task to his/her delegated nurse by sending a patient-staff task in MedTech32."

46. The medical centre's desktop computers have access to an intranet, including links to guidelines for follow-up of referral letters that apply to the medical centre doctors.

Referral receipt by Waitemata DHB

47. Regarding Dr A's referral being addressed to a registrar, Waitemata DHB added that "gastroenterology registrars only receive and accept referrals for specialist gastroenterology assessment from general practitioners if the patient requires acute admission to hospital".

48. The Waitemata DHB processes in place at the time allowed for "real time" acknowledgement of receipt of a primary care referral. This was via an automatic acknowledgement electronic message (termed "HL7") generated and sent to the referrer on receipt of the referral and again following triage of the referral (see examples below). No receipt message for Dr A's referral of 20 April was generated.

24 April 2012 visit to Emergency Department

49. On 24 April 2012, Mr C went to the Emergency Department (ED) at the public hospital with a painless right groin swelling. He was assessed as a triage category 4.[15]

50. The ED specialist who assessed Mr C, Dr E, told HDC that Mr C had no infective symptoms. She gained a history from Mr C that was different from that obtained by Dr A four days previously. Dr E said that Mr C reported episodes of constipation, which he attributed to piles, but was having bowel movements. There was no mention of frequent passage of any blood or mucous, or weight loss. He had a non-tender swelling, which was soft, with no firm mass. A vascular examination was normal. He had a few small lymph nodes in his groin, which were non-tender.

51. Dr E found a reducible 2cm x 2cm mass in the right groin, believed to be an inguinal hernia, and instigated a referral to the general surgical team for this.

52. Dr E did not suspect any hernia strangulation or incarceration, and deemed it a non-emergency hernia, not warranting admission. Dr E advised Mr C to follow up with his GP in one to two days' time.

[14] The medical centre operates signage for patients, stating: "For all important abnormal results we will contact you as soon as we receive your results from the laboratory or radiology service …"

[15] The Australasian Triage Scale states that category 4 is "[p]otentially serious, or potential adverse outcomes from delay > 60 min, or significant complexity or severity, or discomfort or distress".

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53. The ED discharge summary identifies that Mr C had been referred to the general surgical team, but the discharge summary was sent in error to Mr C's former GP. Eventually, on 7 May 2012, it was re-directed to Dr A.

54. Waitemata DHB told HDC that Dr E's referral to the surgical team (regarding the hernia) was then graded as being below the access threshold, and therefore declined, and Mr C was returned to the care of Dr A.

Blood results

55. On 28 April 2012, Mr C's blood results (taken on 20 April) returned a normal haemoglobin level, normal ferritin,[16] normal (ie, negative for) coeliac antibodies, and one positive faecal occult blood result.

DHB general surgical outpatients decline message (1)

56. On 10 May 2012, the DHB sent an electronic message to Dr A advising that a referral to the surgical team, received 26 April 2012 (Dr E's referral), had been declined owing to waiting list management.

57. The records state:

> "10 May 2012, Modify Referral
> Referral/discharge status: Declined Referral Request
> Primary Care Provider: [Dr A]
> [NHI]
> Date Referral Received: 26 April 2012
> Specialty Referred to: General Surgery
> Rejected Reason: Wait List Management
> Clinic Name: Waitemata"

58. The DHB advised that a hard copy letter, dated 9 May, was also sent to Dr A declining the referral. This letter is not on the DHB file provided to HDC, and the medical centre told HDC that it did not receive a hard copy letter relating to this declined referral.

59. Dr A said: "When on 10 May 2012 I received the letter from Waitemata DHB declining the [surgical] referral for [Mr C], I believed that this related to my [gastroenterology] referral dated 20 April."

60. The discharge summary from the ED visit on 24 April 2012 arrived in Dr A's inbox, but the note that there had been a resulting referral to general surgery was overlooked by Dr A.

61. Dr A told HDC:

> "I believed the specialists wanted [Mr C] to be re-referred when his condition was characterised by more significant symptoms and signs. This was confirmed by a

[16] Ferritin (a protein found inside cells) stores iron for later use.

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follow-up letter dated 13 July 2012 stating that the access threshold had not been met and that no appointment would be given unless there was a significant change in [Mr C's] clinical condition when he should be re-referred."

62. Dr A advised HDC that he had reviewed the ED discharge letter and noted the absence of any complaint about persisting significant bowel symptoms, and assumed the treatment he supplied to have resolved Mr C's symptoms.

63. Dr A also said that the hospital had indicated that Mr C's symptoms were not severe enough to warrant urgent review, and that his differential diagnoses of Mr C's symptoms at the first presentation were broad.

64. Mr C did not return for review until 2 July 2012, despite the ED discharge summary recommending follow-up with his GP in one to two days, and Dr A having previously recommended follow-up, albeit as needed.

2 July 2012 visit to the medical centre

65. On 2 July 2012, Mr C went to the medical centre for a third time. A nurse recorded his weight as 66kg. He saw locum Dr D. Mr C presented indicating he had had ongoing weight loss for two years, loose and frequent motions, and continued PR mucus/bleeding. He also appeared to have scabies.

66. Mr C told Dr D that he was concerned that he had not received a gastroenterology appointment from the public hospital.

67. Dr D sent another gastroenterology referral to Waitemata DHB on 2 July 2012.

68. Dr D recorded on 2 July 2012:

> "[mid-fifties] European male with 2 yr hx of alternating bowel habit and weight loss. [Faecal Occult Blood Test] + ve (x1) ? any sinister cause for further assessment/ management please … ongoing alternating bowel habit & weight loss for 2 yrs. Gets diarrhoea mixed with mucus & bloods (up to 20 times on some days) & occasional constipation … rectal exam unremarkable nil bleeding or PR mass."

69. The blood and faeces results of 28 April 2012 were provided with the 2 July 2012 referral (ie, no anaemia, normal ferritin, normal CRP, no red or white cells on faecal microscopy, a single positive faecal occult blood result, a negative coeliac screen).

70. Dr A's previous referral of 20 April 2012 was noticed by Dr D, and non-receipt of the referral was then confirmed with the DHB referral clerk.

71. Dr D recorded:

> "DW [discussed with] ref [referrals] clerk at WDHB — did not receive any gastro [gastroenterology] referral."

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72. Waitemata DHB has confirmed that it advised Dr D on 2 July that it had not received an earlier referral from Dr A on 20 April 2012.

73. Dr D advised Dr A of this development, and they discussed making a re-referral, and Dr D instigated a second referral for Mr C to gastroenterology.

DHB general surgical outpatients decline message (2)

74. On 14 July 2012, the DHB sent an electronic message to Dr A in relation to "a referral to the surgical team, received 3 July 2012". Despite no such referral to the Waitemata DHB general surgery department having been made, the electronic message advised that it had been rejected owing to waiting list management:

> "14 July 2012, Modify Referral
> Referral/discharge status: Declined Referral Request
> Primary Care Provider: [Dr A]
> [NHI]
> Date Referral Received: 3 July 2012
> Specialty Referred to: General Surgery
> Rejected Reason: Wait List Management
> Clinic Name: Waitemata"

75. A hard copy standard letter, dated 13 July 2012, was sent from Waitemata DHB Booking and Scheduling Services to Dr A confirming the electronic message. The letter was not copied to Mr C. It was date stamped as received by the medical centre on 16 July.

76. The DHB decline letter states:

> "Thank you for referring your patient for a General Surgery Outpatient Assessment.
>
> Based on the information contained in your referral, we are unfortunately unable to see your patient for assessment on this occasion as your patient has not reached our access threshold. They are [re]turned to your care for ongoing management. No further action will be taken and your documentation is returned.
>
> Please re-refer if there is any significant change in your patient's clinical condition …"

DHB assessment and prioritisation of gastroenterology referral

77. The referral from Dr D to the Gastroenterology Department, received by Waitemata DHB on 3 July, was assigned on 12 July as a P2 priority — to be seen for specialist assessment within six weeks.[17]

[17] See Appendix B. For completeness, a P1 priority referral meant that, based on the guidelines, the patient should be seen on the next possible list within 2 weeks.

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78. The following electronic receipt was sent by Waitemata DHB to Dr A on 29 July, indicating that waiting time for the appointment was unknown:

> "29 July 2012, Modify Referral
> Referral/discharge status: Referral on waiting list
> Primary Care Provider: [Dr A]
> [NHI]
> Date Referral Received: 3 July 2012
> Specialty Referred to: Gastroenterology
> Waiting List Priority: 2
> Expected Waiting Time: Is Unknown
> Clinic Name: Waitemata."

79. The referral from Dr D had taken 26 days to be triaged, graded, and a decision communicated back to the primary care referrer.

80. The DHB told HDC that the steps taken by the DHB following receipt of Dr D's referral were:

- The hard copy faxed referral was date stamped (on 3 July) at the central referrals office and a grading form attached.
- It was given to the Gastroenterology Department clerk.
- It was logged in the Patient Information Management system (PIMS) on 3 July. Any open or active referrals were checked. None existed for Mr C. A new referral was created.
- The referral was placed in a grading folder.
- A specialist gastroenterology grader collected the referral and graded it (on 12 July).
- The referral was then given to the clerk to be waitlisted for colonoscopy.
- The gastroenterology clerk updated the PIMS log with the grading information and generated a waiting list acknowledgement to Mr C. An HL7 message was sent to the GP.
- The gastroenterology clerk then filed the referral in a specialty referral folder, which was then handed to the booking and scheduling clerk.

81. The DHB advised that referral waiting list acknowledgement letters are not kept on the patient clinical file, and HDC has been unable to clarify whether Mr C received such a letter. The DHB provided a copy of its current standard referral waiting list acknowledgement letter, which it advised had not changed since 2012. The letter states:

> "…
>
> Your referral has been graded by a specialist and has been accepted. You will receive an appointment in due course …
>
> …

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If you experience any change in your condition, or have any concerns you should contact your general practitioner who will continue to oversee your condition and provide treatment. Your GP can request review of your referral if your condition changes."

82. The DHB told HDC that it was not possible from its records to determine the clinician who graded the referral in this case.

Regional priority 2 access criteria

83. The referral from Dr D was given a priority 2 (P2) grading — procedure within 6 weeks — using the Auckland Regional Priority Access Criteria for Outpatient Colonoscopy 2010/2011.[18]

84. The relevant P2 regional access criteria state:

- "…
- Changed bowel habits (looser, more frequent), age > 60 years
- Rectal bleeding without anal symptoms, age > 60 years
- Rectal bleeding plus changed bowel habits (looser, more frequent)
- Fe deficiency anaemia (male <110 and age; female < 100 post menopausal/GI symptoms/positive family history/positive FOB)
- Positive FOB (appropriately collected in asymptomatic patient) age > 50 years
- IBD diagnostic …"

85. The access criteria also state: "Alarms: unexplained weight loss, anaemia, abdominal mass. Referrals not easily fitting into one category will be considered on an individual basis by consultant."

86. The DHB was of the view that the P2 grading given to Mr C's referral of 2 July was clinically appropriate.[19]

87. Despite the DHB's booking service being aware on 2 July of Mr C's lost referral of 20 April, the 10-week delay did not appear to be factored into the grading.

88. The DHB told HDC that P2 priority allocation was reported back to GPs with expected waiting times "unknown", because "long patient waiting lists for diagnostic tests including colonoscopies was, and is, a recognised national problem", and that the DHB was unable to provide GPs and patients with a time in which the patient would be seen.

89. The DHB's response to HDC also stated that from 1 July 2012, the Ministry introduced diagnostic wait time indicators for colonoscopy, including reporting requirements for district health boards. Relevant to this case, that includes that 50% of

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[18] See Appendix B.

[19] Auckland Regional Priority Access Criteria for Outpatient Colonoscopy 2010/2011 were superseded at Waitemata DHB by Referral Criteria for Direct Access Outpatient Colonoscopy, 21 November 2012. http://www.health.govt.nz/system/files/documents/pages/referral_criteria_for_direct_access_outpatient_colonoscopy.pdf (see Appendix C).

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people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days).

Presentation to the medical centre, 17 August

90. Mr C presented to the medical centre again on 17 August 2012, and was seen by a locum doctor who reported that Mr C was aware that he was on the waiting list for gastroenterology specialist review. At that stage, it was five weeks since Waitemata DHB had graded the referral as P2 priority. Mr C's weight was recorded by a nurse as 66kg.

91. The locum doctor recorded that it was "sometimes painful when passing stools, bleeding is less now o/e [on examination] Abd [abdomen] soft, non tender, no palpable lumps not pale PR [rectal examination] not repeated as it has been done recently. P [Plan] Wait for hospital review medications."

Presentation to ED

92. On 11 September 2012, Mr C presented to the public hospital Emergency Department with frank haematuria (blood in the urine). Mr C also had marked hepatomegaly (enlarged liver). Mr C had still not received an appointment for specialist gastroenterology review, and it was then nine weeks since Waitemata DHB had graded the referral as P2 priority on 12 July 2012.

93. An ED specialist, identified Mr C's concerns as follows:

    1. Weight loss of 14kg over one year[20] with poor appetite
    2. Swollen right leg (one week)
    3. Inguinal hernia right groin (9 weeks)
    4. Alternating bowel habit — variable constipation to mucousy bloody loose stool.

94. On rectal examination, the ED specialist identified a "firm craggy mass with some stricture at finger tip depth with copious ooze of blood stained mucus on removal of glove".

95. The ED specialist suspected a rectal carcinoma and, the following morning, transferred Mr C to another hospital (Hospital 2).

96. Colonoscopy and CT scanning revealed enlarged lymph nodes and advanced metastatic carcinoma of the rectum.

97. The ED consultant noted in her discharge summary of 11 September 2012:

    > "Pt has been under GP for altered BO for last 9–12 months —> currently awaiting a gastroenterology r/v with scope — appt not allocated yet."

[20] In the period from 22 November 2011 to 17 August 2012, the primary care notes record a weight loss of 2kg, from 68 to 66kg.

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98. A faxed letter to Waitemata DHB Gastroenterology Services dated 17 September 2012 from the medical centre stated:

> "… Dear Dr. This is just for your information that the above patient ([Mr C]) had been referred twice to Gastro OPC on 20/04/2012 and 02/07/2012 by [Dr A] and [Dr D] respectively prior to his recent admission to hospital … thank you for your assessment."

99. Mr C had DHB medical oncology and radiation oncology follow-up in October 2012.

100. Sadly, Mr C later died in hospice care.

Other relevant information

101. The National Endoscopy Quality Improvement Programme (NEQIP) 2012–2014, funded by the Ministry of Health and aimed at improving endoscopy services in New Zealand, was rolled out across New Zealand in 2012.[21] It included the associated Global Rating Scale (GRS)[22] software tool, which began a staged national roll-out in January 2013.

102. As mentioned earlier, from 1 July 2012, the Ministry of Health introduced diagnostic wait time indicators for colonoscopy, including reporting requirements for DHBs: 50% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); 50% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days); and 50% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date.[23] As part of that initiative, the "National Referral Criteria for Direct Access Outpatient Colonoscopy" were issued in March 2013.

103. In June 2013, the Ministry of Health advised HDC that it was monitoring all DHBs and colonoscopy waiting times, and was communicating directly with DHB clinical leaders regarding prescribed timeframes for urgent or routine colonoscopies.

104. Waitemata DHB also told HDC:

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[21] The National Endoscopy Quality Improvement Programme (NEQIP) was a multipronged approach to improving the quality of endoscopy services by optimising clinical performance and endoscopy unit performance, and enhancing training and assessment. It was a two-year programme (November 2012–November 2014) and was operationally based at the Bay of Plenty District Health Board. The overarching aim of the Programme was to facilitate safe, patient-focused services that are efficient, accountable and sustainable. See: http://www.bopdhb.govt.nz/neqip/#sthash.uyz1zUF8.dpbs.

[22] The NEQIP uses a New Zealand version of the England-based Global Rating Scale (NZGRS), which ties together the elements of training and assessment, individual quality and unit quality. The NZGRS is a web-based self-assessment tool that provides a quality framework for service improvement enabling services to monitor progress against the endoscopy standards. A knowledge management system containing resources to support improvement of endoscopy services can then be used to attain those standards. See: http://www.bopdhb.govt.nz/neqip/nz-global-rating-scale/#sthash.MR2j5krp.dpuf.

[23] An original target date of 1 July 2013 was extended by the Ministry of Health to 1 July 2014, and the target was also increased to 60%.

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"[We have] done a lot of work to manage the colonoscopy waiting list. This includes an investment … in the commissioning of an endoscopy suite, recruiting technically skilled nurses, redesigning the working pattern of senior medical officers to provide additional capacity, a review of our gastroenterology waiting lists to ensure cases have been given the appropriate grading, and introduction of a revised grading and audit system."

Subsequent changes to practice

105. HDC was informed of the following changes to practice:

a) Dr A told HDC that he has now altered his practice in terms of tracking referrals, in that he now uses the PMS reminder tools. Dr A advised that referrals are now made electronically at the medical centre, and this is routine practice.

b) Dr A stated that he now advises patients that they should contact the practice by telephone or return to see him if they have not received any information from the provider that they have been referred to within three weeks, depending on the nature of the referral. (Acute referrals would be followed up urgently.)

c) The medical centre told HDC that this complaint was recorded as a significant event. The lessons to be learnt from the case were discussed at a GP peer review meeting at the medical centre. The meeting was facilitated to avoid any potential hindsight bias. Clinical guidelines on the follow-up of investigations and referrals were reviewed to ensure that they reflected best practice.

d) In June 2014, the medical centre underwent Royal New Zealand College of General Practitioners (RNZCGP) Cornerstone re-accreditation. RNZCGP advised HDC that re-accreditation was achieved in September 2014.[24]

106. Waitemata DHB told HDC that improvements have been made in terms of working towards the promptness of referral grading and GP notification (to within 10 working days of receipt of referral),[25] reduction in wait list for non-urgent colonoscopies, at least 50% of P1 referrals being seen within the recommended waiting time, and progress towards achieving at least 50% of P2 referrals being seen within the recommended waiting time.

Responses to provisional opinion

107. Dr A responded that, as he had previously submitted and explained why he acted as he did and the changes he had made to his practice, he had no further comments. He provided a letter of apology for forwarding on to Mr C's daughter.

108. The medical centre told HDC that it had nothing further to add.

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[24] RNZCGP Cornerstone Programme staff advised HDC that the medical centre's re-accreditation was considered among visits to other medical practices.

[25] The Ministry of Health Elective Services Patient Flow Indicators indicate that DHB services are to appropriately acknowledge and process at least 90% of all patient referrals within 10 working days. See: http://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services/elective-services-and-how-dhbs-are-performing/about-elective-services-patient-flow-indicators.

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109. In response to my provisional opinion, Waitemata DHB stated:

> "… At the time [Mr C] was referred for a colonoscopy the Ministry of Health's (MOH) wait time indicator was for 50% of P2 patients to have their colonoscopy within six weeks. It was not possible for Waitemata DHB to say, when advising patients that their referrals had been accepted, whether they would be among the 50% who would be seen within six weeks.
>
> The current Ministry wait time indicator for colonoscopy for P2 patients is 60% within six weeks and there is still no maximum waiting time. Nevertheless Waitemata DHB can now advise that we expect that all P2 colonoscopies are undertaken within four months. We have amended our letter to patients indicating the current expected waiting time, and also advises patients to see their GP if their condition changes … We hope that the amended letter will give patients greater clarity as to the timeframes for their procedures and their GPs the ability to determine what is a reasonable waiting time for a patient and put appropriate checks and follow-up processes in place. We note however that certainty of waiting times is a longstanding problem not just for Waitemata DHB but for all DHBs."

Opinion: Dr A — Breach

110. When Mr C first presented to Dr A on 20 April 2012, he had concerning symptoms that included a significant change in his bowel habit (including Mr C's reference to needing to go to the toilet up to 40 times a day), blood from the rectum, and reported weight loss. Given the nature of these symptoms, I have concerns about aspects of the care and management of Mr C by Dr A.

Standard of Care — Breach

Differential diagnoses

111. I received expert in-house clinical advice from Dr David Maplesden, an experienced and vocationally registered general practitioner. Dr Maplesden referred to the relevant primary care referral guideline, which stated: "A person aged 40 years and older reporting rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting for 6 weeks or more should be referred urgently to a specialist."[26] He advised:

> "I do not think it was reasonable to consider a diagnosis of IBS above that of colorectal cancer given the 'alarm' features mentioned, but [Dr A] did acknowledge both diagnostic possibilities in his management strategy."

112. Dr Maplesden further advised:

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[26] New Zealand Guidelines Group, *Suspected cancer in primary care: guidelines for investigation, referral and reducing ethnic disparities*. Wellington: New Zealand Guidelines Group; 2009.

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"[Mr C] is likely to have fulfilled criteria for urgent specialist referral … although the duration of his new symptoms was not noted. He did not fulfil the diagnostic criteria for irritable bowel syndrome as pain did not appear to be a feature of the presentation, or at least was not documented as such. Furthermore, he had several alarm features which necessitated exclusion of sinister pathology prior to a diagnosis of IBS being made — these included male, aged over 50 years at first presentation, nocturnal symptoms, weight loss and rectal bleeding.[27] The reference cited states that further investigation is required in these circumstances to exclude gastrointestinal malignancy and inflammatory bowel disease as a cause for the symptoms. It seems [Dr A] did recognise this situation and he made a referral for specialist review. The referral letter included a copy of the consultation notes."

113. Although it is evident from his referral that Dr A did concurrently turn his mind to more sinister pathology, I am critical of Dr A's focus on IBS in these clinical circumstances, and for not classifying his referral of Mr C for specialist review as urgent.

Information to Mr C regarding follow-up

114. At the 20 April 2012 appointment, Dr A documented follow-up as "review as needed". Dr A did not: arrange scheduled follow-up; provide information and advice relating to action Mr C should take if his symptoms persisted or worsened; and did not provide Mr C with an approximate expected timeframe for the referral.

115. The Medical Council of New Zealand position statement on safe practice in an environment of resource limitation[28] in relation to dealing with outpatients states:

"24. A doctor who has a patient in a booking system for treatment, should advise that patient, to the best of their ability, how long they could expect to wait for treatment and must notify the patient if his or her priority changes …"

116. I consider that in the clinical circumstances, more structured follow-up instructions and information should have been given to Mr C by Dr A.

117. As I have stated previously, 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.[29]

118. Dr Maplesden advised:

"Given the severity of [Mr C's] symptoms, I am mildly critical that more structured follow-up was not scheduled at this appointment to determine response to treatment and in order to expedite a referral if the symptoms persisted at the

[27] BPAC. Irritable Bowel Syndrome. BPJ. October 2007;9:36–42.
[28] Medical Council of New Zealand. Statement of safe practice in an environment of resource constraint. August 2008. https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf.
[29] See Opinion 10HDC00974, 15 June 2012. Available at www.hdc.org.nz.

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current rate (passage of blood and mucous per rectum up to 40 times daily) in spite of the treatment provided."

119. I agree, and, in my view, Dr A should have told Mr C the approximate expected timeframe for the referral, what steps to take if such timeframes were exceeded, and what to do should his symptoms remain or worsen — the oft-termed "safety net" advice.

Faxed referral follow-up actions

120. Dr A's referral to gastroenterology of 20 April 2012 included a copy of his consultation notes, and he said that he followed the process adopted by the medical centre for collating and sending referrals at that time. He understood that the referral had been faxed by administrative staff.

121. Dr Maplesden advised:

> "With respect to the referral provided by [Dr A] to [WDHB] on 20 April 2012, I think it was reasonable for [Dr A] to have assumed the referral was sent according to the processes in place within the medical centre at [the] time …"

122. I accept Dr Maplesden's advice, and I consider it reasonable for Dr A to expect that the medical centre's administration processes in place after he gave the referral information to administration staff would have resulted in the referral being faxed to the DHB Gastroenterology Department.

123. However, although not a requirement set out in the medical centre's guidelines, there was an expectation in the clinic that referrals/results would be followed up by doctors using the MedTech electronic reminder system (per the Task Manager function outlined in the clinic guideline). Dr A did not follow this process for Mr C's referral.

124. Doctors who refer patients to a specialist need to take reasonable steps, and have processes in place, to follow up the referral and check whether appropriate action has been taken.

125. I note that the reminder system in use was reliant on input into MedTech from the general practitioner making the referral, and was not an automatically set reminder once the referral was faxed.

126. Dr A's referral was dated 20 April 2012, and the DHB decline message that he incorrectly interpreted was received some three weeks later. A reminder message to Dr A within this time period would have alerted him that a decision on the referral had not yet been received from the DHB. This was a lost opportunity to identify that his referral had not been received by the DHB.

127. Dr Maplesden advised that in his view Dr A's failure to set a follow-up reminder was a moderate departure from accepted practice.

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128. Since the events in question, Dr A has altered his practice in terms of tracking referrals, in that he now uses the PMS reminder tools. However, I would have expected appropriate alert and follow-up systems to have already been systematically in use by Dr A at the time of these events, and I am critical that they were not.

Approach taken in response to decline message

129. On 10 May 2012, an electronic message was received by Dr A from the DHB General Surgical Outpatients advising that the referral to the surgical team, received 26 April 2012, had been declined owing to waiting list management.

130. The decline message outlined that it related to a general surgery referral (and not Dr A's 20 April 2012 gastroenterology referral). However, the portion of the 24 April ED discharge summary relating to the resulting referral to general surgery was overlooked by Dr A. He presumed, based on the ED discharge summary, that Mr C had improved, and he mistakenly thought at that point that the decline message related to his gastroenterology referral dated 20 April.

131. Dr Maplesden advised that the history contained in the ED discharge summary would not normally be assessed as part of the triage referral process when the referral has come from primary care, so the possibility that there had been an apparent improvement in symptoms was not available to the triaging clinician, and could not therefore be the basis for declining the referral. In addition, Dr Maplesden advised that, in his view, temporary response to treatment should not have obviated the need for referral given the preceding history and, in particular, the "alarm" symptoms, which were not consistent with a diagnosis of IBS.

132. Dr Maplesden said that, in his view:

> "[A]ny reasonable clinician would have reflected that a [man in his mid-fifties] with recent change in bowel pattern, passage of blood and mucous per rectum up to 40 times daily, and weight loss fulfilled the criteria for urgent specialist assessment under any circumstance whether or not there was some possible secondary reassurance (by way of the [ED] discharge summary of 24 April 2012) that the symptoms might have settled somewhat."

133. Dr A's failure to accurately identify that the decline message related to a general surgical referral on a different date was a further lost opportunity for Dr A to have verified what happened to his original referral to gastroenterology of 20 April 2012, and why an investigation or specialist review that he felt was clinically indicated, had not gone ahead.

134. I am concerned not only at Dr A's misinterpretation of the message, but also that, despite the significance and severity of Mr C's symptoms, Dr A accepted that DHB specialists wanted Mr C to be re-referred when his condition was characterised by more "significant symptoms and signs".

Advocating for his patient

135. Mr C did not subsequently return for primary care review until 2 July 2012, when he was reviewed by Dr D, who appropriately queried with the DHB whether it had

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received the gastroenterology referral dated 20 April. The DHB confirmed that it had not. Dr D, after a discussion with Dr A, instigated a further gastroenterology referral letter dated 2 July 2012, which Dr Maplesden advises was of a satisfactory standard.

136. While I acknowledge that there can be many challenges faced by primary care providers in liaising with secondary services and advocating for a patient regarding a referral, I am mindful of Dr Maplesden's advice on this point:[30]

> "I do not believe there was any occasion, following [Dr A's] review of [Mr C] on 20 April 2012, that the clinical indication for him to be considered for urgent specialist review actually disappeared. For this reason, I am concerned at the passivity of the approach taken by [Dr A] …
>
> …
>
> I remain therefore moderately critical of the fact that, following the declined referral dated 10 May 2012, [Dr A] did not advocate on behalf of his patient to ensure he received the investigations that were clinically indicated by contacting the DHB in writing or by telephone to ensure they were fully aware of the clinical picture and to establish why they were declining a patient who met clinical guideline recommendations for urgent specialist referral."

137. In relation to Dr A having not contacted Mr C, Dr Maplesden advised:

> "Additionally, [Dr A] might have contacted [Mr C] to review his current symptomatology on receipt of the DHB 'decline' letter, particularly as the clinical situation was likely to warrant re-referral. I do not think it was reasonable to assume [Mr C] was 'OK' because he did not present himself for review. [Mr C] was under the impression he was on the waiting list for gastroenterology review and/or colonoscopy and his symptoms, although severe and disruptive, were relatively longstanding. There was no particular reason for [Mr C] to return for review without specific instruction from [Dr A] unless he became aware he was not on the waiting list for DHB outpatient review or he developed new or worsening symptoms (as he did in September 2012)."

138. I accept Dr Maplesden's advice. The Medical Council of New Zealand's position statement on safe practice in an environment of resource limitation, in relation to medical practice where available services are restricted, states:

> "09. Doctors have a responsibility, as advocates for their patients, to seek the provision of appropriate resources for their patients' care and report any deficiencies to the appropriate authorities …"

139. I am concerned that Dr A did not take steps to follow up with Mr C (to check on his symptoms) or to proactively contact the DHB (to query the 10 May decline message). In my view, Dr A failed to advocate for his patient with the DHB.

[30] Dr Maplesden's advice (at Appendix A) draws on the New Zealand Medical Association's Code of Ethics. Available at: http://www.nzma.org.nz/sites/all/files/Code_of_Ethics.pdf.

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Conclusion

140. In summary, I have concerns about a number of aspects of Dr A's care of Mr C. I am critical of Dr A's focus on IBS in the clinical circumstances, and that he did not classify his referral of Mr C for specialist review as urgent on 20 April 2012.

141. I also consider that Dr A should have advised Mr C of the approximate expected timeframe for the referral, what steps to take if such timeframes were exceeded, and what to do should his symptoms remain or worsen, and, in particular, Dr A should have put in place an appropriate MedTech alert and follow-up reminder relating to his referral.

142. Dr A failed to accurately identify that the decline message he received related to a general surgical referral on a different date and, despite the severity of Mr C's symptoms, Dr A inappropriately accepted that DHB specialists wanted Mr C to be re-referred if his condition altered or worsened.

143. Dr A failed to contact Mr C to check on his symptoms, and did not effectively advocate for his patient by contacting the DHB to query its 10 May decline message.

144. Taking into account these deficiencies, in my opinion Dr A did not provide services to Mr C with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Opinion: Medical Centre — Adverse comment

145. As I have commented on in a previous case, medical providers, such as primary care medical centres, need to have robust systems in place to ensure that mistakes and omissions are identified at an early stage to prevent harm being caused.[31]

146. The Royal New Zealand College of General Practitioners document, "Aiming for Excellence",[32] states that practices should have an "effective system for the management of clinical correspondence, test results, and other investigations".

147. Dr A has indicated that he is confident the 20 April 2012 referral to the DHB was sent. In contrast, the DHB has stated that it received no referral from Dr A on 20 April.

148. The medical centre provided evidence that the medical centre's MedTech address book contained the correct fax number for the Waitemata DHB central referrals office, but in the absence of a hard copy confirmation printout there is no evidence available to confirm that the referral was sent. I am unable to make a finding about whether the referral was sent and received.

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[31] See Opinion 10HDC00974, 15 June 2012. Available at www.hdc.org.nz.

[32] "Aiming for Excellence". RNZCGP Standard for New Zealand General Practice 2011–2014. The Royal New Zealand College of General Practitioners, Wellington, 2011.

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149. Copies were provided to HDC of GP clinic guidelines in place at the medical centre at the time in relation to follow-up of referrals. I note that those guidelines were used by a number of different medical practices run by the organisation operating the medical centre.

150. At the time of these events, the setting of a follow-up reminder in MedTech by a doctor was governed by an appropriate guideline, but it was not mandatory. In addition, there was no automatic reminder set once the referral was confirmed as having been sent and received. Rather, it was left to individual doctors to manually input reminders on a case-by-case basis.

151. This case exemplifies that there is an inherent risk in not having an automatic reminder system in place. Had the medical centre required its doctors to set reminders, or had in place an automatic system for such reminders, Dr A would have, in all likelihood, been alerted to the gastroenterology referral having not been actioned by the DHB.

152. However, Dr Maplesden advised:

> "The processes in place for handling of referrals at [the medical centre] in April 2012 were consistent with common practice at the time, and I note electronic DHB referrals are now the accepted standard which should reduce the risk of 'lost' referrals in the future."

153. I accept Dr Maplesden's advice. While I am concerned that the processes in place at the medical centre at the time did not include a mandatory or automatic reminder system, or the clinic retaining hard copy records of fax transmission beyond three months, I note that the medical centre has made changes to its DHB referral systems, which are now electronic, in line with the accepted standard today.

Opinion: Waitemata DHB

154. District health boards owe patients a duty of care in handling referrals to outpatients from GPs within the district (and from other DHBs).[33] A specific aspect of the duty of care is the duty to co-operate with other providers to ensure continuity of care. I am concerned about aspects of the DHB's processing and management of referrals relating to Mr C.

Referral processing — Adverse comment

155. The referral to the Gastroenterology Department was received by the DHB on 3 July. The DHB has outlined the usual steps taken following receipt of such a referral. The referral was logged into the PIMS on 3 July. On 12 July, the referral was assigned as a P2 priority — to be seen for colonoscopy within six weeks.

[33] Opinion 09HDC01883. 15 June 2012.

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156. The referral priority was consistent with the Auckland Regional Priority Access Criteria for Outpatient Colonoscopy 2010/2011. However, I am concerned that the DHB electronic receipt was not sent to Dr A for a further 17 days, on 29 July, and that it indicated that the waiting time for a specialist appointment was "unknown".

157. In total, the referral to the DHB took 26 days to be triaged, graded, and communicated to the primary care referrer. I am concerned that despite the DHB's booking service being aware on 2 July of Mr C's lost referral of 20 April, the 10-week delay did not appear to be factored into the grading.

158. I also note that by the time of his presentation to ED on 11 September 2012, two months after the DHB had graded the 3 July referral, Mr C still had not received a scheduled appointment for specialist assessment.

159. In addition, although Waitemata DHB provided electronic receipt messages to Mr C's primary care provider, Dr A, regarding the status of referrals to its specialist services, it was unable to provide any clear information to Dr A about the estimated timeframe in which specialist gastroenterology assessment/investigation would occur for his patient, such that would have allowed Dr A to discuss potential treatment options with his patient. In my view, this inability to provide any estimate of timeframe was a contributing factor to suboptimal continuity of care.

160. In my view, the total turnaround time and processing of Mr C's referral, the failure to take into account the misplaced earlier referral, and the communication with Dr A were substandard. However, I note the Ministry of Health targets at the time, and that the DHB has indicated that improvements have subsequently been made in terms of promptness of referral grading and notification (toward the goal set by the Ministry of Health of 10 working days of receipt of referral).

Information provided to Mr C regarding referral processing — Breach

Timeframes

161. Right 6(1)(c) of the Code provides that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including advice of the estimated time within which the services will be provided.

162. On 29 July 2012, Waitemata DHB provided Dr A with an electronic message regarding the 2 July 2012 referral to gastroenterology, its P2 status, and the waiting time being "unknown".

163. The DHB provided HDC with a copy of its then standard referral waiting list acknowledgement letter. That letter advises a patient that a referral has been graded by a specialist and has been accepted, and that he or she will receive an appointment "in due course". It also advises that if any change in condition is experienced, the patient should contact his or her GP who, it advises, can request review of the referral.

164. The DHB told HDC that P2 priority allocation was reported back to GPs with expected waiting times "unknown", because "long patient waiting lists for diagnostic

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tests including colonoscopies was, and is, a recognised national problem". The DHB told HDC that it was unable to provide GPs and patients with a timeframe in which the patient would be seen by a specialist.

165. While I acknowledge that the broader issue of resource constraint creates challenges in this regard, I am concerned at the lack of information provided to Mr C (and his primary care provider) in this case.

166. I note Dr Maplesden's view on the effect on primary care:

> "[T]his inability to give the referrer and the patient any degree of certainty or expectation regarding waiting times is a significant problem and is frustrating for all concerned. It impairs the ability of the GP to determine what is 'reasonable' in terms of expected waiting time for a patient, and therefore to put in place appropriate safety netting and follow-up processes."

167. In my view, and as this Office has previously stated, a receiving DHB should acknowledge receipt of the referral, promptly notify the patient (with a copy to the patient's GP) of an approximate or estimated timeframe for an appointment, and then notify the patient (again, with a copy to the GP) of the subsequent scheduled appointment time.[34] Patients should receive clear information when waiting for resource-constrained specialist procedures when levels of uncertainty and anxiety may be high.

168. I am pleased to note that in response to my provisional opinion, Waitemata DHB has made changes to its referral waiting list acknowledgement letter. It provided an example of the Gastroenterology Department's revised letter. It advises the patient that "We have received a referral from your doctor requesting a Gastroenterology procedure. Your referral has been graded by a specialist and has been accepted. The current maximum waiting time is four (4) months. You may receive an appointment before this, if we are able to offer an earlier date." The letter concludes that if the patient experiences any change in their condition, or has any concerns, they should contact their general practitioner. However, I remain of the view that not advising both the patient and the referring doctor of an estimated timeframe in Mr C's case was suboptimal. Involving patients at all stages of the communication process also provides a check in the system to correct errors and ensure that communications do not go astray.[35]

Conclusion

169. While I acknowledge that providing a consumer with accurate advice about an estimated time within which an appointment will be provided is difficult in a context of resource uncertainty, I am concerned that Mr C received no information at all from Waitemata DHB relating to that issue, or any guidance about what he should do if he had not heard from the DHB within a specified time frame. Therefore, in my view, Waitemata DHB breached Right 6(1)(c) of the Code.

[34] Opinion 07HDC19869, 3 October 2008.
[35] Opinion 09HDC01883, 15 June 2012.

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Grading clinician — Other comment

170. While there is nothing to suggest that an inappropriate referral grading occurred in this case, I am concerned that the DHB has not been able to provide clarity about the identity of the clinician grading the 2 July gastroenterology referral.

171. Clear and accurate records should be in place that will subsequently allow for purposeful quality assurance activities and/or audit of the referral grading process.

Recommendations

172. In my provisional opinion, I recommended that Dr A provide a formal written apology to Ms B for his breaches of the Code. In response, Dr A provided HDC with a formal written apology, which has been forwarded to Ms B.

173. I recommend that Dr A have an independent GP colleague conduct a random audit of 30 referrals to specialist secondary services that he has instigated in the last 12 months, to check that appropriate requests have been made and appropriate reminders have been put in place to follow up such referrals.

174. I recommend that the medical centre, within three months of issue of this report, provide me with:

a) An evaluative report on the effectiveness of all system and policy changes implemented as result of this case. The report should include reference to:

    i. Systems in place to ensure that all doctors put in place appropriate reminders to follow up referral letters sent to secondary specialist services for assessment or investigation. For example, generating automated electronic reminder alerts at a nominated interval after a referral has been sent.

    ii. Retaining evidence in the electronic record of confirmation that referrals to secondary services have been sent and received.

175. I recommend that within three months of this report being issued, Waitemata DHB:

a) Revise templates used by its Booking and Scheduling Services, to ensure that referral waiting list acknowledgement letters are copied to the patient's GP.

b) Conduct an audit of the processing time of all referrals requesting investigative procedures received by the Gastroenterology Service in the last 12 months, from receipt through to formal notification of a decision, stratified according to whether or not they were accepted for specialist investigation.

176. I also recommend that Waitemata DHB provide a formal written apology to Ms B for its breach of the Code. The apology is to be sent to HDC in the first instance, within three weeks of issue of this report, for forwarding to Ms B.

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Follow-up actions

177. • A copy of this report with details identifying the parties removed, except the expert who advised on this case and Waitemata DHB, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr A's name in the accompanying covering correspondence.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Waitemata DHB, will be sent to the Director-General of Health (Ministry of Health), and DHB Shared Services, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent clinical advice to the Commissioner

The following clinical advice was obtained from Dr David Maplesden.

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her late father, [Mr C], by [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have reviewed the information on file: complaint from [Ms B]; responses from [the medical centre]; responses from [Dr A]; responses from Waitemata DHB (WDHB); [the medical centre's] clinical notes; WDHB clinical notes; advice from HDC advisor Dr P Warring. [Ms B] complains about delays in the diagnosis of her father's rectal carcinoma. A timeline of events is present on the file and will not be recounted in detail here. It is apparent there were issues with WDHB management of this case with respect to handling of referrals and brief comment is provided on this at the conclusion of this advice.

2. With respect to the referral provided by [Dr A] to [Hospital 2] on 20 April 2012, I think it was reasonable for [Dr A] to have assumed the referral was sent according to the processes in place within [the medical centre] at this time, and I do not think it is possible to determine whether the deficiencies in processing which allowed the referral to be unacknowledged occurred within [the medical centre] or WDHB. [The medical centre] have provided documentary evidence that the referral was completed and faxed to a WDHB number but it cannot be determined that the fax was ever received or how the referral was handled by WDHB if it was received. The processes in place for handling of referrals at [the medical centre] in April 2012 were consistent with common practice at the time and I note electronic DHB referrals are now the accepted standard which should reduce the risk of 'lost' referrals in the future.

3. With respect to [Mr C's] management at [the medical centre] when he presented on 22 November 2011, I feel management was consistent with expected standards. [Mr C] had a six-month history of outlet type bleeding associated with a prolapsing rectal lump. There were no additional 'red flags' for colorectal cancer and [Mr C] did not appear to be at increased risk for the disease (regarding family or personal medical history). Abdominal and rectal examinations were unremarkable. He was prescribed medication for haemorrhoids and to prevent constipation and was instructed to return for review in part to address additional medical problems the doctor did not have time to address at this visit. There is mention of prescribing colchicine, the rationale for which is unclear, but it does not appear the drug was actually prescribed.

4. [Mr C's] next visit to [the medical centre] was with [Dr A] on 20 April 2012. Symptoms were extreme and concerning with change of bowel pattern to frequent loose motions and passage of blood and mucous per rectum up to 40 times daily, even through the night, and *lost significant amount of weight.* However, there was no complaint of abdominal pain. There is a well documented clinical examination with no abnormality noted on abdominal or rectal examination. A provisional

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diagnosis of *IBS/?any sinister* is recorded. [Dr A] confirms in his response this refers to irritable bowel syndrome, and treatment was provided for this (anti-spasmodic and bulking agent). [Mr C] was concurrently referred for gastroenterology review and blood and faeces tests. Follow-up was recorded as *r/v as needed.*

Comments:

(i) [Mr C] is likely to have fulfilled criteria for urgent specialist referral (see below) although the duration of his new symptoms was not noted. He did not fulfil the diagnostic criteria for irritable bowel syndrome as pain did not appear to be a feature of the presentation, or at least was not documented as such. Furthermore, he had several alarm features which necessitated exclusion of sinister pathology prior to a diagnosis of IBS being made — these included male, aged over 50 years at first presentation, nocturnal symptoms, weight loss and rectal bleeding[36]. The reference cited states that further investigation is required in these circumstances to exclude gastrointestinal malignancy and inflammatory bowel disease as a cause for the symptoms. It seems [Dr A] did recognise this situation and he made a referral for specialist review. The referral letter included a copy of the consultation notes. Given the severity of [Mr C's] symptoms, I am **mildly critical** that more structured follow-up was not scheduled at this appointment to determine response to treatment and in order to expedite a referral if the symptoms persisted at the current rate (passage of blood and mucous per rectum up to 40 times daily) in spite of the treatment provided. I feel also that [Mr C] should have been given some idea of expected time frames with respect to both a likely specialist appointment (or when to notify [Dr A] if he had not received an appointment), and response to therapy (when to notify [Dr A] if symptoms were not improving) if structured follow-up had not been arranged. However, I note some follow-up was documented.

(ii) In a further response dated 4 June 2014, [Dr A] stated he considered IBS in his differential diagnosis as *presenting symptoms were not consistent with exam findings and I was seeing him for the first time.* He notes that following initiation of treatment (bulking agent and antispasmodic), [Mr C's] symptoms apparently improved (with reference to ED discharge summary — see below) and he notes (retrospectively) that [Mr C's] weight remained stable (65–66kg) between 20 April and 1 October 2012. He emphasises also that [Mr C] did not return for review until 2 July 2012 implying the symptoms were settling. For the reasons discussed in section 4(i) above I do not think it was reasonable to consider a diagnosis of IBS above that of colorectal cancer given the 'alarm' features mentioned, but [Dr A] did acknowledge both diagnostic possibilities in his management strategy. Since the events in question, [Dr A] has altered his practice in terms of tracking referrals in that he now uses the PMS reminder tools and routinely informs patients to contact him if they have not been contacted regarding an appointment within a defined time frame. These are appropriate remedial measures but I recommend also that [Dr A] review the cited BP article on IBS.

[36] BPAC. Irritable Bowel Syndrome. BPJ. October 2007;9:36–42

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5. As a basis for subsequent clinical comments I have referred to relevant local cancer guideline recommendations[37]:

(i) *A person aged 40 years and older reporting rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting for 6 weeks or more should be referred urgently to a specialist.* I feel [Mr C] fitted these criteria and this situation did not alter at any stage prior to his eventual diagnosis.

(ii) *A person presenting with a palpable rectal mass (intraluminal and not pelvic), should be referred urgently to a specialist, irrespective of age.* While a palpable rectal mass was evident at the time of diagnosis in September 2012 no mass had been palpable on rectal examination before that time, and this could still be consistent with all rectal examinations having been performed competently.

(iii) *A man of any age with unexplained iron deficiency anaemia and a haemoglobin of 110 g/L or below, should be referred urgently to a specialist.* [Mr C] showed no signs of iron deficiency anaemia in blood tests taken on 23 April 2012 and this was somewhat reassuring although did not detract from the need for his symptoms to be investigated further by colonoscopy unless an obvious alternative and treatable cause was found in the interim (and no such cause was found).

(iv) *A person presenting with a right-sided abdominal mass, should be referred urgently for a surgical opinion.* [Mr C] apparently did not have an abdominal mass when reviewed by [Dr A] on 22 April 2012. No mass was noted when [Mr C] was reviewed by [Dr D] at [the medical centre] on 2 July 2012 or by [a locum doctor] at [the medical centre] on 17 August 2012. In the interim, [Mr C] had been noted to have a right inguinal mass (which he had first noted the previous day), diagnosed as a hernia, in [the public hospital] ED on 24 April 2012. On 12 September 2012 [Mr C] was assessed in [Hospital 2] ED where marked hepatomegaly (6cm below costal margin) and right groin mass was noted. The groin mass was found on subsequent CT scan to be a mass of enlarged lymph nodes (18–33mm in size) with no reference to an associated hernia. The possibility is therefore raised that the right groin lump noted in [ED] on 24 April 2012 was related to lymphadenopathy rather than hernia (although a surgical referral had been made in any case and the assessing MO is confident a hernia was present — see section 11), and the adequacy of the abdominal examination undertaken by [Dr D] on 2 July 2012 (*no mass, no organomegaly*) and [the locum doctor] on 17 August 2012 might be questioned. However, it is probably not possible to determine unequivocally whether abnormalities on abdominal examination should have been determined by these doctors before they were noted by the [Hospital 2] ED doctors. I note neither [Dr D] nor [the locum doctor] are currently practising in New Zealand and neither is available for further comment.

(v) *Faecal occult blood and carcinogenic embryonic antigen testing are of little value in a person with symptoms suggestive of colorectal cancer and should not*

[37] New Zealand Guidelines Group. Suspected cancer in primary care: guidelines for investigation, referral and reducing ethnic disparities. Wellington: New Zealand Guidelines Group; 2009.

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be used. [Mr C] gave a clear history of overt rectal blood loss and there was therefore no clinical value in seeking results of occult blood testing given the limitations of this test and the fact positive or negative results would not impact on the need for colonoscopy.

(vi) *For a person with equivocal symptoms, a complete blood count may help in identifying the possibility of colorectal cancer by demonstrating iron deficiency anaemia. This should determine if a referral is needed and whether the person should be urgently referred to a specialist.* [Mr C] had clearly abnormal symptoms of marked change in bowel pattern to frequent passage of blood and mucous up to 40 times daily associated with weight loss. While demonstration of iron deficiency might have resulted in more urgent attention, failure to demonstrate anaemia did not obviate the need for colonoscopy.

(vii) *For a person where the decision to refer to a specialist has been made, a complete blood count may be considered to assist specialist assessment in the outpatient clinic. For a person where the decision to refer to a specialist has been made, no examinations or investigations other than an abdominal and rectal examination, and a complete blood count should be undertaken as this may delay referral.* [Dr A's] management was consistent with these recommendations.

(viii) *A person at low risk of colorectal cancer with a significant symptom (rectal bleeding or a change in bowel habit) and a normal rectal examination, no anaemia and no abdominal mass, should be managed by a strategy of treat, watch and review in three months.* Given [Mr C's] age (over 50 years) and nature and severity of his symptoms (rectal bleeding and change in bowel pattern, both to an extreme degree, and unexplained weight loss) I do not feel this recommendation applied in his case.

6. The Medical Council of New Zealand makes the following recommendations in its publication Good Medical Practice[38]:

(i) (section 2) *When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes: adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate; providing or arranging investigations or treatment when needed; taking suitable and prompt action when needed, and referring the patient to another practitioner or service when this is in the patient's best interests.*

(ii) (section 29) *The care or treatment you provide or arrange must be made on the assessment you and the patient make of his or her needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.*

(iii) Supplementary guidance — referring patients

Referring involves transferring some or all of the responsibility for some aspects of the patient's care. Referring the patient is usually temporary and for a particular purpose, such as additional investigation, or treatment that is outside

[38] Medical Council of New Zealand Good Medical Practice (current edition 2013). http://www.mcnz.org.nz/assets/News-and-Publications/good-medical-practice.pdf

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your scope of practice. When you refer a patient, you should provide all relevant information about the patient's history and present condition. You must appropriately document all referrals.

When you order a test and expect that the result may mean urgent care is needed, your referral must include one of the following: your out-of-hours contact details; the contact details of another health practitioner who will be providing after-hours cover in your absence.

You must also have a process for identifying and following up on overdue results.

You should ensure that the patient is aware of how information about them is being shared and who is responsible for providing treatment, undertaking an investigation and reporting results.

7. From the New Zealand Medical Association Code of Ethics[39]:

(i) *Consider the health and well being of the patient to be your first priority.*

(ii) *Accept a responsibility to advocate for adequate resourcing of medical services and assist in maximising equitable access to them across the community.*

(iii) *Doctors should ensure that every patient receives appropriate available investigation into their complaint or condition, including adequate collation of information for optimal management.*

(iv) *Doctors have an obligation to draw the attention of relevant bodies to inadequate or unsafe services. Where doctors are working within a health service they should first raise issues in respect of that service through appropriate channels, including the organisation responsible for the service, and consult with colleagues before speaking publicly.*

8. Based on the information reviewed, it appears there was a series of events subsequent to [Dr A] having referred [Mr C] to [Hospital 2] gastroenterology leading to the delay in [Mr C's] diagnosis of advanced rectal cancer as noted below.

9. The referral letter dated 20 April 2012 may or may not have been received and the DHB denies any record of receipt of the referral. The DHB processes in place at the time allowed for 'real time' acknowledgement of receipt of the referral via an automatic acknowledgement message generated and sent to the referrer on receipt of the referral and again following triage of the referral. However, confusion arose regarding a referral made to surgical outpatients shortly after [Dr A] had made his referral to the gastroenterology service (see below).

10. [Mr C] was referred to [Hospital 2] surgical outpatients following a review in [Hospital 2] ED on 24 April 2012 after presentation with a groin swelling diagnosed as inguinal hernia. The ED discharge summary did identify this referral had been organised but the discharge summary went to [Mr C's former GP] as he was apparently identified on hospital documentation as [Mr C's] current primary

[39] Available at: http://www.nzma.org.nz/sites/all/files/Code_of_Ethics.pdf

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health provider. It is a little unclear why subsequent documentation relating to this referral was sent to [Dr A] (around 9 May 2012) if he was not identified as [Mr C's] provider. However, [Dr A] states he did receive a copy of the discharge summary following redirection from the DHB.

11. It remains unclear why the [Hospital 2] ED MO assessing [Mr C] on 24 April 2012 (four days following his assessment by [Dr A]) gained a very different history to that obtained by [Dr A]. The ED notes do not refer specifically to frequent passage of blood and mucous together with weight loss, but merely to *mild constipation but has ongoing haemorrhoids.* In a response from the ED MO dated 20 June 2014, the nature of the history obtained was confirmed as was the presence of a soft non-tender groin swelling of recent onset consistent with a hernia. A few small insignificant groin nodes were also noted at the time. It is not possible to determine whether or why [Mr C] withheld information relating to his symptoms, or the possibility that his symptoms had temporarily improved with the use of the bulking agent prescribed by [Dr A] a couple of days previously, but this was a missed opportunity for surgical outpatients to be made aware of [Mr C's] previously reported and concerning bowel symptoms and weight loss in addition to the newly diagnosed hernia.

12. The surgical referral letter dated 24 April 2012 originating from ED became the subject of subsequent correspondence to [Dr A] from [Hospital 2], with an electronic message received on 10 May 2012 stating *declined referral request ... Wait List Management.* This note identified the referral having been received on 26 April 2012 by Surgical Outpatients but did not identify the source of the referral. [Dr A] states he perceived this letter to mean *that a further referral would be needed if [Mr C's] symptoms persisted or changed.* He states also that he had reviewed the ED discharge letter previously (see above) and noted the absence of any complaint about persisting significant bowel symptoms, and assumed the treatment he supplied may have resolved [Mr C's] symptoms. Furthermore, [Mr C] did not return for review until 2 July 2012 despite the ED discharge summary stating he had been recommended *follow-up with GP in 1–2 days* and [Dr A] having previously recommended follow-up *as needed.*

13. Once [Mr C] returned for follow-up on 2 July 2012 ([Dr D] [the medical centre]) with persistence of his symptoms of frequent passage of blood or mucous (2-year history noted), and weight loss (amongst other unrelated medical problems), he was re-referred for specialist review and the 'missing' referral from 20 April 2012 was noted. The referral letter was directed to gastroenterology outpatients and included: *ongoing alternating bowel habit & wt loss for 2yrs, gets diarrhoea mixed with mucous & bloods (up to 20 times on some days) & occasional constipation ...* Normal abdominal and rectal examination noted. Blood and faeces results were included (no anaemia, normal ferritin, normal CRP, no red or white cells on faecal microscopy, single positive faecal occult blood result, negative coeliac screen). Previous referral on 20 April 2012 was noted and that non-receipt of the referral had been confirmed with the referral clerk. The referral letter was of a satisfactory standard.

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14. The steps taken following receipt of [Dr D's] referral were outlined in a response from WDHB dated 20 June 2014. The DHB states it has not been possible to determine the clinician grading the referral. The referral was given a priority 2 grading (procedure within 6 weeks) using access criteria in force at the time (Auckland Regional Priority Access Criteria for Outpatient Colonoscopy 2010/2011). I have reviewed a copy of these criteria and it is apparent the referral priority was consistent with these guidelines. However, I feel more consideration might have been given to the 'alarm' symptom of unexplained weight loss, to the severity of [Mr C's] symptoms (extreme frequency of bowel movements), and to the recorded fact that his initial referral some 10 weeks previously had apparently not been received ie he had already been waiting 10 weeks from the time of his intended referral, which presumably would also have been classified as P2 (six week wait) had it been received when intended. I am mildly critical that these factors were not given due consideration in the grading process, when clinical 'common sense' might have taken precedence over the access criteria recommendations.

15. The criteria for priority 1 categorisation (next possible list, within 2 weeks) are: *known cancer, to pre-operatively check for synchronous cancer; abdominal mass; imaging (CT colonography/barium enema suggestive of tumour; ?IBD with severe symptoms; palpable/visible rectal tumour … Alarms: unexplained weight loss, anaemia, abdominal mass.* I am mildly critical that the grading process in place did not ensure the identity of the clinician grading referrals is consistently available and trust that current processes enable such identification for audit purposes. I note what could be perceived as a discrepancy between the colonoscopy priority access criteria in force at the time and the criteria for 'urgent referral' noted in the primary care guidelines discussed in section 5, depending on whether review within six weeks could be determined as an adequate response to an 'urgent' referral. I note also that current access criteria (revised since the time of [Dr D's] referral) would have placed [Mr C] in the 'two week' priority range and are more consistent with the primary care guidelines.

16. On 29 July 2012 the DHB notified [Dr A] that [Mr C] was on the gastroenterology wait list as priority 2 but expected waiting time *is unknown.* The reasons for this lack of specificity regarding waiting time given by the DHB relate to lack of resource and difficulty managing the colonoscopy wait list which was/is a national problem. However, this inability to give the referrer and the patient any degree of certainty or expectation regarding waiting times is a significant problem and is frustrating for all concerned. It impairs the ability of the GP to determine what is 'reasonable' in terms of expected waiting time for a patient, and therefore to put in place appropriate safety netting and follow-up processes. There should be an expectation that if a GP follows evidence-based national primary care referral guidelines (reference 2) when making a referral, it is reasonable that the DHB also will manage the patient within the intention of the guidelines — specifically that if the guidelines recommend urgent specialist referral, the DHB will see the patient as an 'urgent' patient. However, there should also be an expectation that the GP referral letter contains all the information required to make an accurate

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prioritisation (including family history, treatment history and relevant investigation results) and in a form that can be easily followed — not just a 'copy and paste' of often irrelevant consultation notes and results that the triaging clinician has to wade through to extract important clinical data. The referral letter from [Dr D] I think was reasonable in this regard.

17. The DHB response indicates improvements have been made since [Mr C's] referral in terms of promptness of referral grading and GP notification (within 10 working days of receipt of referral), reduction in wait list for non-urgent colonoscopies, at least 50% of P1 referrals being seen within the recommended waiting time, and progress towards achieving at least 50% of P2 referrals being seen within the recommended waiting time. This of course is of no relevance to [Mr C] who waited almost a month for his referral to be triaged and despite being categorised P2 (which might have been reasonable acknowledging the discrepancy between referral guidelines and access priority guidelines at the time), by 10 weeks post referral (when he presented to [ED] and was transferred to [Hospital 2]) he had still not been given a date for his procedure. I do not think this was satisfactory but it is for the Commissioner to decide whether 'lack of resource' is a reasonable response to what, in my opinion, were unreasonable delays under the circumstances.

18. I do not believe there was any occasion, following [Dr A's] review of [Mr C] on 20 April 2012, that the clinical indication for him to be considered for urgent specialist review actually disappeared. For this reason, I am concerned at the passivity of the approach taken by [Dr A] when he perceived on 10 May 2012 that the referral he had made on [Mr C's] behalf had been declined by the DHB because ([Dr A's] perception) the symptoms were not severe enough for the DHB to consider a current assessment. I think any reasonable clinician would have reflected that a 53 year old man with recent change in bowel pattern, passage of blood and mucous per rectum up to 40 times daily, and weight loss fulfilled the criteria for urgent specialist assessment under any circumstance whether or not there was some possible secondary reassurance (by way of the [ED] discharge summary of 24 April 2012) that the symptoms might have settled somewhat. These features of [Mr C's] history were noted on the referral form [Dr A] assumed had been received by [Hospital 2]. The history contained in the ED discharge summary would not normally be assessed as part of the triage referral process when the referral has come from primary care so the possibility there had been an apparent improvement in symptoms was not available to the triaging clinician and could not therefore be the basis for declining of the referral — nor should temporary response to treatment have obviated the need for referral given the preceding history described including the 'alarm' symptoms not consistent with a diagnosis of IBS. I remain therefore moderately critical of the fact that, following the declined referral dated 10 May 2012, [Dr A] did not advocate on behalf of his patient to ensure he received the investigations that were clinically indicated by contacting the DHB in writing or by telephone to ensure they were fully aware of the clinical picture and to establish why they were declining a patient who met clinical guideline recommendations for urgent specialist referral.

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19. Additionally, [Dr A] might have contacted [Mr C] to review his current symptomatology on receipt of the DHB 'decline' letter, particularly as the clinical situation was likely to warrant re-referral. I do not think it was reasonable to assume [Mr C] was 'OK" because he did not present himself for review. [Mr C] was under the impression he was on the waiting list for gastroenterology review and/or colonoscopy and his symptoms, although severe and disruptive, were relatively longstanding. There was no particular reason for [Mr C] to return for review without specific instruction from [Dr A] unless he became aware he was not on the waiting list for DHB outpatient review or he developed new or worsening symptoms (as he did in September 2012).

20. In not undertaking either or both of the tasks discussed above, I feel [Dr A] failed to ensure [Mr C] received the treatment he had felt was indicated based on his initial clinical assessment of [Mr C] and his symptoms, that management (requirement for specialist assessment/colonoscopy) also being recommended in current relevant guidelines. [The medical centre] management has confirmed there was expectation 'important' referrals/results would be followed up by way of the PMS electronic reminder system (Task Manager) and [Dr A] did not follow this process. These are moderate departures from expected practice, mitigated to some extent by the other factors involved in the delayed diagnosis discussed above, many of which involved DHB processes, but exacerbated by the fact that [Mr C's] symptoms, as reported to [Dr A], were at the more severe end of the spectrum in terms of their nature, prominence and disruption."

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Appendix B — Regional Priority Access Criteria

AUCKLAND REGIONAL PRIORITY ACCESS CRITERIA FOR OUTPATIENT COLONOSCOPY

Priority 1: next possible list, within 2 weeks

- Known cancer, to pre-operatively check for synchronous cancer
- Abdominal mass
- Imaging (CT colonography/barium enema) suggestive of tumour
- ?IBD with severe symptoms
- Palpable/visible rectal tumour (these patients can also be offered rigid sigmoidoscopy during FSA Gastroenterologist/Surgeon)

Priority 2: within 6 weeks

- Changed bowel habits (looser, more frequent), age >60 years
- Rectal bleeding without anal symptoms, age >60 years
- Rectal bleeding plus changed bowel habits (looser, more frequent)
- Fe deficiency anaemia (male <110 and age; female <100 post menopausal/GI symptoms/ positive family history/ positive FOB)
- Positive FOB (appropriately collected in asymptomatic patient) age >50 years
- IBD diagnostic

Priority 3: Within 3 months

- Imaging/sigmoidoscopy shows polyp >10mm
- Changed bowel habits (looser, more frequent), age 40-60 years
- Overdue surveillance (HNPCC and FAP patients only)

Priority 4: Within 6 months

- Imaging/sigmoidoscopy shows polyp <10mm
- Younger patients (age <40 years) who require colonoscopy after FSA Gastroenterologist or Surgeon
- All Surveillance

Priority 5: Return to GP:

- Referrals not meeting criteria of the above categories

Alarms: unexplained weight loss, anaemia, abdominal mass.

Referrals not easily fitting into one category will be considered on an individual basis by consultant.

Auckland Regional Priority Access Criteria for Outpatient Colonoscopy 2010/2011

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Appendix C — Referral Criteria for Direct Access Outpatient Colonoscopy

Referral Criteria for Direct Access Outpatient Colonoscopy

These criteria are designed to cover the **majority** of indications for referral for colonoscopy by general practitioners and non-gastrointestinal specialists.

Appropriate access for gastrointestinal (GI) endoscopy is highly ranked as a quality indicator.

Colonoscopy services are **encouraged** to provide direct access to colonoscopy for appropriate patients.

For patients falling outside these criteria, referral for a first specialist assessment (FSA) may need to be considered.

Patients requiring urgent colonoscopy for suspicion or assessment of inflammatory bowel disease would usually be inpatients or under the care of a specialist.

Few symptoms in primary care practice have greater than a five percent positive predictive value for colorectal cancer (CRC).

In referring a patient for colonoscopy the referrer should:

- inform the patient about the procedure
- ensure they are willing to undergo the procedure
- consider the ability of the patient to tolerate both the bowel preparation and the procedure
- consider whether the patient being referred will benefit if they are frail, have multiple co-morbidities or advanced malignancy (generally referral implies they are well enough to tolerate further treatment) *(Refer to Comments for Services section items 5)*
- if the patient has had a colonoscopy in the preceding five years, ensure there is a clear indication to repeat the procedure (the 'miss' rate of lesions > 1cm following a well performed colonoscopy is approximately six percent).

Two week category
Known or suspected CRC (on imaging, or palpable, or visible on rectal examination), for pre-operative procedure to rule out synchronous pathology
Unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin below the local reference range) *(Refer to Comments for Services section items 1 & 2)*
Altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years

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Referral Criteria for Direct Access Outpatient Colonoscopy – Final (5 December 2012)

Six week category
Altered bowel habit (looser and/or more frequent) > six weeks duration, aged ≥ 50 years
Altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign anal causes treated or excluded), aged 40-50 years
Unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥ 50 years
Unexplained iron deficiency anaemia (haemoglobin below local reference range) *(Refer to Comments for Services section items 1 & 2)*
New Zealand Guidelines Group (NZGG) Category 2[1] Family History plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 40 years
NZGG Category 3[1] Family History plus one or more of altered bowel habit (looser and/or more frequent) > six weeks duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥ 25 years
Suspected/assessment inflammatory bowel disease (consider FSA)
Imaging reveals polyp > 5mm

Not accepted
Acute diarrhoea < six weeks duration - likely infectious aetiology and self-limited
Rectal bleeding aged less than 50 years (normal haemoglobin[JM1] [E2]) - consider FSA or flexible sigmoidoscopy if no anal cause
Irritable bowel syndrome (may require specialist assessment)
Constipation as a single symptom
Uncomplicated computed tomography (CT) proven diverticulitis **without** suspicious radiological features
Abdominal pain alone without any 'six week category' features
Decreased ferritin aged < 50 years with normal haemoglobin
Abdominal mass - refer for appropriate imaging
Metastatic adenocarcinoma unknown primary - six percent is due to CRC and in the absence of clinical, radiological, or tumour marker evidence of CRC, colonoscopy is not indicated.

[1] Refer to: New Zealand 2012 Guidelines (www.nzgg.org.nz): Guidance on Surveillance for People at Increased Risk of Colorectal Cancer

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Referral Criteria for Direct Access Outpatient Colonoscopy – Final (5 December 2012)

Surveillance notes *(Refer to New Zealand Guideline: Guidance on Surveillance)*

Direct access surveillance colonoscopy should be offered to those meeting the guideline criteria where 'offer' is the recommendation. 'Consider' is less imperative than 'offer'.

Family history of colorectal cancer – individuals in the categories below should be offered direct access surveillance colonoscopy.

- Category 2 and 3 as recommended in the New Zealand 2012 guidelines (www.nzgg.org.nz): Guidance on Surveillance for People at Increased Risk of Colorectal Cancer.
- Category 3 as recommended by the New Zealand Familial Gastrointestinal Cancer Service or a bowel cancer specialist.

Personal history of low risk adenomas

- The recommendation for surveillance after detection at index colonoscopy of adenomas associated with a low risk of developing colorectal cancer is to consider colonoscopy at five years – if the colonoscopy is negative (ie, no adenomas are found) then *stop* surveillance'.
- People at low risk are defined as no parental history of colorectal carcinoma and with one or two small (<10 mm) tubular adenomas at index colonoscopy.
- This recommendation is based on moderate quality evidence which shows the time taken for advanced metachronous adenomas to develop in five percent of people at low risk was 10.4 years, in 10 percent it was 12.2 years and in 20 percent it was 16.2 years.

Comments for Services

1. The indication of iron deficiency anaemia requires a haemoglobin level below the local reference range in association with a low ferritin level.
2. Menstruation is the commonest cause of iron deficiency anaemia in women - for women aged less than 55 years a menstrual history should be obtained prior to referral. Coeliac disease and urinary loss should also be excluded.
3. Use of faecal occult blood tests collected in asymptomatic individuals is not currently recommended in New Zealand (outside of the Waitemata District Health Board Bowel Screening Pilot) and should not be encouraged.
4. CT colonography is an acceptable alternative investigation to colonoscopy for many indications in the 'six week category' where direct mucosal visualisation is not required.
5. CT colonography may also be the most appropriate investigation for patients with significant co-morbidities but who meet the criteria for investigation.[2]
6. Only patients who, at referral, have high suspicion of cancer[3] are covered in the 'two week category' and included in the following Ministry of Health faster cancer treatment indicators.
   - Length of time taken for a patient referred urgently with a high-suspicion of cancer to:
     - have their first specialist assessment (best practice maximum 14 days)
     - receive their first cancer treatment (best practice maximum 62 days).

[2] The referrer should consider the ability of the patient to tolerate both the bowel preparation and the procedure.

[3] High suspicion of cancer is defined as a person presenting with clinical features typical of cancer, or has less typical signs and symptoms but the clinician suspects that there is a high probability of cancer.

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7. Patients whose diagnosis is incidental, or as a result of 'six week category' investigation, are included in the following indicator.
   - Length of time taken for a patient with a confirmed diagnosis of cancer to receive their first cancer treatment from decision-to-treat (best practice maximum 31 days).
8. There is some variance in age criteria and timeframes between these criteria for referral to direct access colonoscopy and the timeframes for specialist referral in the guideline Suspected Cancer in Primary Care referenced below. The timeframes in this document are based on what is considered to be achievable and compatible with good practice.
9. Initially, prioritisation within the routine category referrals may still occur at a service level.
10. Patients with atypical presentations outside these criteria may require colonoscopy, usually following specialist referral.

References

Suspected Cancer in Primary Care. Guidelines for investigation, referral and reducing ethnic disparities. New Zealand Guidelines Group. Ministry of Health 2009

Guidelines for the management of iron deficiency anaemia Gut 2011Oct; 60(10)01309-16.Epub 2011 May 11

The diagnostic value of symptoms for colorectal cancer in primary care: a systematic review. Br J Gen Pract. 2011 May;61(586):e231-43

New Zealand 2012 guidelines (www.nzgg.org.nz): Guidance on Surveillance for People at Increased Risk of Colorectal Cancer

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