Medical Practitioner, Dr A

The Company

A Report by the

Health and Disability Commissioner

(Case 14HDC01030)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. On 11 October 2013, Ms B had an appointment at Medical Centre 2 for a routine cervical smear and sexually transmitted infections screening. Her appointment was with Dr A, an overseas trained doctor who had recently moved to New Zealand.

2. On 19 October 2013, Ms B's cervical smear results were sent to Dr A's inbox. The results recommended that Ms B be referred for a colposcopy.[1] Dr A did not action the abnormal result or inform Ms B of the result.

3. Dr A told HDC that he does not recall seeing Ms B's smear result in his inbox, but thinks he must have viewed the result on its arrival and then probably he filed the result without actioning it.

4. Dr A said that before he started working at Medical Centre 2 numerous people orientated him on various topics and protocols over several hours. He said that when it came to the topic of smears, he was told that the doctors routinely did not do the smears, and that there were specific nurses who took care of that. Furthermore, he was under the impression that if he did a smear, then the results would be followed up by those nurses. He said that he was not familiar enough with the system to know that the results would not be seen by the nurses, and that the results would be filed back into the office Medtech system only through his "inbox".

5. The Company that owned Medical Centre 2 (The Company) told HDC that the nurses were not responsible for results ordered by other clinicians unless specifically asked to follow them up. Its policy was that individual providers were responsible for management of results for all tests ordered by them (including cervical smears). This included ensuring that results were notified to the patient in an appropriate manner (whether by the ordering clinician or passed on with instructions to another staff member to undertake), and that any clinical follow-up indicated was undertaken in a timely and appropriate fashion.

6. Dr A's orientation paperwork records that he was orientated about "results tracking". There is no documentation on what he was told at the time.

7. On Thursday 5 December 2013, the National Cervical Screening Programme enquired as to whether Ms B's colposcopy referral had been made. Dr A was sent a message about this by a Medical Centre 2 nurse, and he referred Ms B to a colposcopy clinic as soon as he received the message.

8. No contact was made with Ms B at that time.

9. Dr A told HDC that because he acted on the referral urgently, he referred Ms B without checking her records or speaking to her. He said that he did not recognise that he had taken Ms B's smear. Dr A said he assumed that it had been carried out by a nurse, and that he was just being asked to do the referral. Furthermore, he said he also assumed that the nurses "would be notifying the patient of the results of the smear and the referral".

[1] A colposcopy is an examination of the cervix using an instrument called a colposcope, which magnifies the cervix and vaginal wall so that any abnormal cells can be seen.

10. On 12 December 2013, the district health board (DHB) received the referral. The DHB sent a letter to Ms B advising of the referral and that an appointment would be sent to her. Ms B did not receive that letter or any further communication from the DHB.

11. Ms B told HDC that the first time she learnt of her abnormal cervical smear (taken on 11 October 2013) was when she received a call from the DHB on 23 June 2014, the day of her colposcopy appointment.

12. On 24 June 2014, Ms B complained about these events directly to Medical Centre 2. Ms B was told that her complaint would be investigated but received no further feedback about it.

Findings

13. By failing to establish that the cervical smear test he ordered had been followed up in a timely and appropriate way, and by failing to review Ms B's clinical notes prior to making the colposcopy referral, Dr A failed to provide services to Ms B with reasonable care and skill and, therefore, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

14. In addition, Dr A also failed to ensure that he discussed the abnormal smear result with Ms B, including the need for a colposcopy referral and her preferences regarding the referral (private or public). This was information that a reasonable consumer, in that consumer's circumstances, would expect to receive. Accordingly, Dr A breached Right 6(1) of the Code.[3]

15. Adverse comment was made about The Company for not ensuring that Dr A had an adequate understanding of its processes in relation to results tracking, and for failing to respond to Ms B when she made a complaint to Medical Centre 2 and was advised that her complaint would be investigated.

Recommendations

16. It was recommended that Dr A:

a) Provide a written apology to Ms B. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms B.

b) Provide evidence to this Office of the subsequent changes he has advised HDC he has made to his practice following these events, within three weeks of the date of this opinion.

c) Undertake a random audit of his clinical records to ensure that patient test results received in the last two years have been followed up appropriately and communicated to patients. Dr A should provide evidence of this audit and its outcome within three months of the date of this opinion.

17. It was recommended that The Company:

[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] 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."

a) Provide a written apology to Ms B, in relation to its handling of her complaint. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms B.

b) Audit clinical staff compliance with requirements for management and communication of results to avoid a repeat of the scenario outlined in this report. The audit is to be conducted over a three month period with a report of the results and actions taken in response provided to this Office within six months of the date of this opinion.

Complaint and investigation

18. The Commissioner received a complaint from Ms B about the services provided to her by Dr A and The Company. The following issues were identified for investigation:

- *Whether Dr A provided Ms B with an appropriate standard of care between 11 October 2013 and July 2014.*
- *Whether The Company provided Ms B with an appropriate standard of care between 11 October 2013 and July 2014.*

19. An investigation was commenced on 3 February 2015.

20. The parties directly involved in the investigation were:

Dr A	Medical practitioner/provider
Ms B	Consumer/complainant
The Company	Provider
Ms C	Practice & Nurse Manager

Also mentioned in this report:

RN D	Registered nurse
Ms E	National Cervical Screening Programme
RN F	Registered nurse

21. Information from the DHB and the National Cervical Screening Programme was also reviewed.

22. In-house clinical advice was obtained from general practitioner Dr David Maplesden (**Appendix A**).

Information gathered during investigation

Background

23. Ms B (38 years old at the time of these events) had been a patient of Medical Centre 2 for many years. Medical Centre 2 is a satellite clinic of Medical Centre 1, which was owned and operated by The Company.

24. Dr A is an overseas trained doctor who has been practising for over 30 years. In 2012 he moved to New Zealand and started working at Medical Centre 2 in January 2013.[4]

Routine cervical smear and STI screening

25. On 11 October 2013, Ms B had an appointment at Medical Centre 2 for a routine cervical smear and sexually transmitted infections screening (STI screening). As her usual GP was not available, her appointment was with Dr A.

26. Ms B's clinical notes for this visit document that the cervical smear specimens and STI screening samples were sent to the laboratory that day.

Test results

27. On 14 and 15 October 2013, the STI screening results were all recorded as normal and were sent electronically from the laboratory to Dr A's inbox at Medical Centre 2.

28. On 19 October 2013, Ms B's National Cervical Screening History Report (the cervical smear results) was also sent electronically from the laboratory to Dr A's inbox. The results recorded "Epithelial cell abnormality"[5] and recommended that Ms B be referred for a colposcopy. The screening report states:

> "There are abnormal squamous cells consistent with a low grade squamous intraepithelial lesion … Positive for … high risk HPV[6] type … Referral for colposcopy is indicated due to positive HrHPV[7] result."

29. Dr A did not action the abnormal result or inform Ms B of the result.

30. Dr A told HDC that he does not recall seeing Ms B's smear result in his inbox, but thinks he must have viewed the result on its arrival and then probably filed the result without actioning it. More specifically, Dr A stated:

> "I would have seen it similar to certain results of tests ordered by specialists coming into my [inbox], which were FYI category. If smears came into my [inbox], I would assume it was one from the nursing smears, given my previous understanding [that nurses generally handle all smears and follow up]. With any other lab [result] at the time I realised it was my responsibility to action it and would promptly do so. But with the smears, I clearly had misunderstood how the system worked in that one particular area and was relying on what I had been told which it turns out I had unwittingly misinterpreted."

Referral for colposcopy

31. The New Zealand National Cervical Screening Program (NCSP) provides a back-up system whereby it contacts the smear taker if it is apparent that recommended follow-up (in this case colposcopy referral) has not been undertaken within three months (ie, if the relevant DHB has not notified NCSP of having received a referral in relation to the particular patient).

[4] Dr A was not vocationally registered as a GP at the time of these events.
[5] Abnormal cells on the the cervix.
[6] Human papillomavirus — a sexually transmitted virus that can cause cervical cancer.
[7] High risk human papillomavirus.

32. On Thursday 5 December 2013, NCSP Regional Service Register Co-ordinator Ms E contacted Medical Centre 1 to enquire whether Ms B's colposcopy referral had been made. Ms E spoke to a registered nurse (RN) who worked at the practice. The RN electronically documented the following in Ms B's medical notes: "[Ms E] from Cervical Screening phoned re: [Ms B's] recent abnormal [cervical] smear result — CIN 1 HPV+ [Ms E] advises [Ms B] needs referring to Colposcopy."

33. On the same day, the RN sent an electronic task reminder via the electronic messaging system to RN D at Medical Centre 2 to ensure that Dr A would be alerted to the abnormal result and refer Ms B for a colposcopy.

34. On Friday 6 December 2013, RN D was on leave. On Tuesday 10 December 2013, the message was actioned by RN D.[8] The task message states: "Task: pls refer pt to colposcopy clinic — thanks." This was recorded as being "urgent" and stated that the patient was Ms B. Dr A received the message and referred Ms B to the colposcopy clinic that same day. He wrote on the referral:

> "[Ms B] was recently seen and had a cervical screening with CIN1[9] and HPV+. I am sending this to you."

35. No contact was made with Ms B at that time. Dr A told HDC that because he acted on the referral urgently he referred Ms B without checking her records or speaking to her. He said:

> "I generated a referral letter … by opening the outbox, and I used the information provided to me by the 'task' message from the nurse. I recognise that I should have at least called [Ms B] to discuss the referral. That would not only have given her an opportunity to be told of the result, but it would also have been the time to talk to her about her preferences for either private or public referral. I apologise also that I didn't do this."

36. Dr A further stated that at this time he did not recognise that he had undertaken the smear on Ms B, and assumed it had been carried out by a nurse, and that he was just being asked to do the referral. He said: "I did not connect the request for the referral with the smear I'd done two months previously."

37. Furthermore, he said that he assumed that the nurses "would be notifying the patient on the results of the smear and the referral".

38. On 12 December 2013, the DHB received the referral.

39. The NCSP Policies and Standards in place at the time stated at Section 6: Providing a Colposcopy service, at Standard 602: "Women who have … a low-grade abnormality and positive hrHPV test, must receive a colposcopy appointment **that should not exceed 26**

[8] As RN D had been away on Friday 6 December 2013, she did not action the task until Tuesday 10 December 2013.

[9] Cervical intraepithelial neoplasia (CIN) is the potentially premalignant transformation and abnormal growth of cells on the surface of the cervix. CIN is not cancer, and is usually curable. CIN1 often returns to normal without treatment, but a repeat cervical screening test (smear) is needed to check that the abnormal cells have resolved.

weeks[10] (emphasis in original) of the colposcopy unit receiving the referral from the smear taker/referrer."

40. On 20 December 2013, a consultant graded Ms B, as per the NCSP Policies and Standards, to be seen within 26 weeks.

41. The DHB told HDC that on 24 December 2013, it sent Ms B a letter advising her that it had received a referral for the colposcopy clinic and that she would be given an appointment time in due course. While the DHB could not provide HDC with a copy of this letter, it provided a copy of an audit history showing that on 24 December 2013 a letter acknowledging the colposcopy referral was sent to Ms B at her given address. Ms B told HDC that she did not receive this notification.

42. The DHB stated that its usual practice would be to then send the patient a letter confirming an appointment time about two to three weeks prior to the scheduled appointment. However, the DHB could not confirm whether a letter was sent to Ms B, as there was no record of the letter or any audit history.

43. Ms B told HDC she received only a call from the DHB on 23 June 2014, the day of the allocated appointment. This was the first time Ms B learnt of the abnormal smear result from her cervical smear taken on 11 October 2013. She said to HDC: "[T]o be ambushed at work on the day of the procedure by the hospital when I had no prior knowledge of what was going on has caused me a great deal of stress and emotional upheaval."

44. On 23 June 2014, a consultant obstetrician and gynaecologist performed the colposcopy and biopsy of a cervical lesion at the hospital. The histology confirmed a low-grade lesion (CIN1). Ms B was discharged back to her GP, who was advised to carry out another smear in six months' time and to refer Ms B back to the DHB if her next smear was abnormal.

Policies and guidelines

45. The Company had no specific policy in place at Medical Centre 2 relating to smear taking. The Company said that its nurse smear takers "in particular" were trained to follow the National Cervical Screening Standards for test result management. However, at the time it did have in place a Patient Test Results Guideline which "applie[d] to all situations where a laboratory or other external test ha[d] been requested for diagnostic purposes" and included the following relevant information:

> "**3. Assigned responsibilities**
>
> …
>
> 3.2. The **doctor** is responsible for authorising blood tests and other external diagnostic procedures.
>
> 3.3. The **doctor** is responsible for following up all results of the external diagnostic tests authorised by him/her.
>
> 3.4. The **doctor or providing nurse** is responsible for advising the patient of the procedure used for follow up of results.

[10] The NCSP Policies and Standards state that one week equals five working days.

3.4.1. The patient has the option of being notified of all test results or

3.4.2. The patient is informed of all test results that need follow up or

3.4.3. Patients are notified that they will only be informed if the test results require follow up.

3.5. Nurses who are able to authorise tests eg, smears and do so are responsible for those results and follow up.

3.6. The doctor and in some cases the nurse are responsible for setting recalls and reminders within the [patient management system] PMS. Where applicable recalls should be set within the screening guidelines for smears, mammograms and immunisations. Clinically, recalls should be set as indicated by the doctor.

…

4. Knowledge Net/Policy

4.1. Referral documents, lab, radiology, cervical screening forms etc are to have a tracking system in place. This tracking system should alert the doctor/nurse if they have not received results from their referrals in the appropriate time frame.

4.2. Doctors must identify to patients both verbally and with practice leaflet (or outbox document) the method used by the practice for patients to receive their results.

…

4.5. Incoming reports are to be viewed by the doctor and the appropriate action identified in the clinical notes and to the nurse for actioning.

4.5.1. Where reports or results regarding the patients are received and there are follow up procedures recommended it is the provider who ordered the tests (eg, the doctor or in the case of smears it may be the nurse,) responsibility to set the recall and ensure that the patient is seen for these follow up tests.

4.6. The nurse is to follow the doctor's instructions from the clinical notes and to contact the patient to inform them. An appointment is made either by the nurse or the receptionist, or the nurse makes an appropriate entry into the clinical notes to document the discussion.

…

6. Outcome measurement

6.1. The practice has a procedure in place to ensure incoming results are seen and actioned by the appropriate member of the practice team who requested these or a designated deputy.

6.2. The practice has a procedure in place to track and manage patient test results, medical reports, investigations and to follow up missing results.

6.3. Patients are provided with information about the procedure for notification of practice results.

6.4. Medical records have a clear indication of the information provided to the patient regarding the follow up of their test results.

…"

Orientation

46. Dr A told HDC:

> "When I came to [the region] [in January 2013], orientation started prior to beginning work … This involved numerous people orienting me on various topics, and protocols of [The Company], over several hours. When it came to the topic of smears, I was … told that the doctors routinely didn't do the smears and that there were specific nurses that took care of that. The person at the time told me[11] that I didn't have to worry about the smears at all, and that these nurses did everything including all the follow up for them. I was being instructed on the many roles the nurses would do for us and that we didn't have to directly do ourselves … I can see now that what was trying to be communicated to me at the time was not what I was hearing. … I was under the impression that if it did occur on occasion that I did a smear, then it would go through the same nursing smear pool. I wasn't familiar enough with the system to know that the results would never be seen by them, and that it would only be filed back into our office Medtech system going into my 'inbox' alone."

47. Dr A also told HDC: "Since I've been at [Medical Centre 2], I've only done one other smear …"

48. On the other hand, The Company told HDC that the nurses are not responsible for results ordered by other clinicians unless specifically asked. It stated that its policy was that individual providers were responsible for management of results from all tests ordered by them (including cervical smears). This included ensuring that results were notified to the patient in an appropriate manner (whether by the provider him- or herself or passed on with instructions to another staff member to undertake), and that any clinical follow-up indicated was undertaken in a timely and appropriate fashion.

49. Dr A's orientation paperwork records that he was orientated about "results tracking". There is no documentation on what he was told at the time.

50. The Company also said that it cannot find any evidence that Dr A was told that all smears are handled by nurses, and it "cannot explain why [Dr A] expected that the nurses would be aware of [Ms B's] test result, other than, that during his orientation, he misunderstood the role nurses working for [The Company] have with regard to performing cervical smears and managing the results of those smears".

Subsequent events

51. On 24 June 2014, Ms B complained verbally about these events directly to Medical Centre 2. She spoke to RN F.

52. The Complaints Policy in place at the time included the following relevant information regarding the procedure to be followed when a complaint was made to the practice:

> "6.5. The General Manager, or delegated person, acknowledges all verbal, written complaints or complaints received via [the management service], in writing within five working days of receipt …

[11] Dr A told HDC that he cannot now recall who gave him this advice.

> 6.6. The appropriate manager leads an internal investigation, carried out in a sensitive manner with a focus on continuous quality improvement which is documented on the complaint form.
>
> 6.61. Send a report of the investigation to the complainant within ten working days. …
>
> 6.6.2. If the complaint has not been resolved within ten working days, forward an interim report to the complainant and send a follow up report to the complainant monthly thereafter until the matter is resolved to the satisfaction of the complainant."

53. RN F recorded the complaint electronically in Medical Centre 2's PMS, and sent a copy to the Practice and Nurse Manager, Ms C.

54. On 25 June 2014, Ms B emailed a formal complaint directly to Ms C. Ms C rang Ms B on or about 26 June 2014 to apologise, and advised her that the complaint would be investigated. Ms C told Ms B that she would hear back regarding her complaint within 20 working days. However, there is no record of how the complaint was managed. Ms B received no further feedback regarding her complaint within the 20 working days. She then lodged a complaint with HDC.

55. Ms C told this Office that after receiving Ms B's complaint, she reviewed Ms B's file and the electronic mailboxes and, "could not identify any system breakdown in our receipt of the test result and concluded that the result had been overlooked by [Dr A] in October". However, Ms C did not convey this to Ms B at the time.

56. Ms C told HDC: "I would like to assure [Ms B] that I considered her complaint very seriously and sincerely apologise for not managing her complaint in the manner it deserved."

57. Ms C also said: "In order to improve my process of complaint management and prevent a repeat of this situation, I have now developed a system of scheduling response dates and setting reminders in my electronic calendar as well as noting them in my diary notebook."

Further information

Dr A

58. Dr A told HDC:

> "I did not appreciate that for any smear I might do, that the results would be going directly into my [inbox] without anyone else seeing it. However I accept that I should have checked on the result a few weeks after I performed the smear."

59. Dr A stated that he is very sorry that Ms B found out about her results in the way that she did. He said:

> "Personally, I will make sure that any smear I take is treated like any other test I order, in that I will take responsibility for following up the outcome of the test and actioning the result in some way.

> While this should not be read as an excuse for my actions, I have been aware of steadily rising number of results arriving in my inbox, as other providers increasingly send copies of investigations done by them, for example in hospital. I am aware of my responsibility to ensure that abnormal results ordered by another practitioner have been appropriately followed up, so this does increase my workload and that of all my colleagues. Getting this additional information is useful for us and I am pleased that I will now have more dedicated time to attend to results."

60. Dr A also said: "Since learning of this error in my understanding, I have gone through everything else in the system to make sure there weren't other areas likewise misunderstood and there weren't."

NCSP

61. The NCSP told HDC that the responsibility to notify patients of their smear result lies primarily with the smear-taker, but that NCSP acts as a "back-up" in case the primary care system fails. NCSP said its usual practice is that abnormal smear results (which are always notified to NCSP if the woman is enrolled in the NCSP, which Ms B was) are notified to the patient by NCSP in a letter generated about a month after the result has been received. NCSP told HDC that on this occasion, Ms B had not been sent the letter that is normally sent one month after the smear test result was generated, advising of her low grade abnormal smear result from October 2013, due to a technical fault[12] (which has since been remedied).

Actions taken since complaint

62. The Company and Dr A stated that they plan to take the following steps to improve Dr A's practice and its systems:

a) Reduce Dr A's patient workload and assign him two 45-minute sessions per day to ensure that he manages his test results and administrative duties.

b) With the support of the Practice Manager and Clinical Director, have Dr A develop a system for managing his administrative duties that includes meticulous test result review.

c) Undertake regular audits of Dr A's provider inbox.

d) Have Dr A review the manner in which he communicates test results to all patients, and ensure that he carries this out at all times.

e) Assist Dr A with process (d) and develop an outbox document that will be for the use of all staff, as a prompt for this conversation with patients.

f) Have Dr A record notification of results to patients in each patient's clinical file.

g) Have Dr A not make referrals to colposcopy without first establishing that the patient has been informed of the result of the smear tests and the need for referral, and given the option of where (public vs private) the patient will receive this treatment.

63. The Company stated that it has already taken the following steps to improve its systems:

[12] A systems issue with the NCSP Register at that time, meant that the triggering of a letter did not occur due to this particular result combination, where a patient had a Low Grade Cytology Result and HPV detected. NCSP said they have contacted other women affected by this issue.

a) As part of ensuring that the responsibilities of all clinicians ordering test results, and the management and communication of these results, is understood by all current staff, this case was presented as an anonymised case study, and staff were reminded of the policies and guidelines available to them.

b) As part of reviewing the orientation for clinical staff to ensure that responsibilities regarding ordering of tests, and the management and communication of results to patients are standardised, understood and adhered to, quick reference flow charts and information handouts were developed, which staff were made aware of, and which are now included in orientation packages for all new clinical staff.

c) When interacting with patients and undertaking or ordering tests, all staff must ensure that the patient understands why the test is being ordered, how the test will assist with ongoing care, how the results will be conveyed to, or able to be accessed by, the patient, and the timeframe in which this will/can be done.

d) Staff were reminded that, when ordering or performing tests, they are to ensure that patients are given the option of accepting ongoing care and where this will be provided, eg, via the public or private system.

Responses to provisional opinion

64. Ms B, Dr A and The Company were given the opportunity to respond to relevant sections of my provisional opinion.

65. Ms B stated that she had no comment to make.

66. Dr A and The Company accepted the findings made and did not have any additional comment to make.

Opinion: Dr A — Breach

Cervical smear test result

11 October 2013 — Cervical smear and STI screening

67. On 11 October 2013, Dr A performed a routine cervical smear and STI screening for Ms B at Medical Centre 2.

68. I obtained expert advice from GP Dr David Maplesden, who advised me that the cervical smear and STI screening were both undertaken in a clinically appropriate manner, and that the standard of clinical documentation was adequate. I accept this advice.

Receipt of test results

69. On 19 October 2013, Ms B's cervical smear results were sent electronically to Dr A's inbox. The results documented abnormal cells and recommended that Ms B be referred for a colposcopy.

70. Dr A does not recall seeing Ms B's smear result in his inbox, but thinks he must have viewed the result on its arrival and then filed it without actioning it. He said he was under the

impression that the nurses actioned all such results, including patient notification. I note that Dr A accepts that he should have "checked on the result a few weeks after [he] performed the smear".

71. At the time, The Company did not have in place a specific policy relating to smear taking at Medical Centre 2. However, it did have a Patient Test Results Guideline in place. The guideline "applie[d] to all situations where a laboratory or other external test ha[d] been requested for diagnostic purposes", and included the following relevant information:

> "**3. Assigned responsibilities**
>
> …
>
> 3.3. The **doctor** is responsible for following up all results of the external diagnostic tests authorised by him/her.
>
> 3.4. The **doctor or providing nurse** is responsible for advising the patient of the procedure used for follow up of results.
>
> 3.6. The doctor and in some cases the nurse are responsible for setting recalls and reminders within the PMS. Where applicable recalls should be set within the screening guidelines for smears, mammograms and immunisations. Clinically, recalls should be set as indicated by the doctor."

72. Dr A's orientation paperwork records that he was orientated with regard to "results tracking".

73. Dr A said that when he started working for The Company and was orientated to its practices:

> "… The person at the time told me that I didn't have to worry about the smears at all, and that these nurses did everything including all the follow up for them. … I can see now that what was trying to be communicated to me at the time was not what I was hearing. … I was under the impression that if … I did a smear, then it would go through the same nursing smear pool. I wasn't familiar enough with the system to know that the results would never be seen by them, and that it would only be filed back into … my 'inbox' alone."

74. The Company told HDC that the nurses are not responsible for results ordered by other clinicians unless specifically asked to do so. As per its Patient Test Results Guideline, individual providers are responsible for management of results from all tests ordered by them (including cervical smears). This includes ensuring that results are notified to the patient in an appropriate manner (whether by themselves or passed on with instructions to another staff member to undertake) and that any clinical follow-up indicated is to be undertaken in a timely and appropriate fashion.

75. The Company cannot find any evidence that Dr A was told that all smears are handled by nurses. It also said that it "cannot explain why [Dr A] expected that the nurses would be aware of [Ms B's] test result, other than, that during his orientation, he misunderstood the role nurses working for [The Company], have with regard to performing cervical smears and managing the results of those smears".

76. Due to the conflicting accounts of the information provided to Dr A during his orientation, I am unable to make a finding as to what Dr A was or was not told about the smear taking and results tracking.

77. Dr Maplesden advised that the correct process on receiving the results would have been for Dr A to provide a referral letter to the appropriate service provider and to enter a smear recall into the PMS at an appropriate interval.

78. Dr Maplesden considered that "unless [Dr A] had requested a copy of the result go to nursing staff (which he evidently had not) or that he sent the result to the nursing e-clipboard rather than filing it (which he did not) it was unlikely nursing staff would be aware [Ms B] had had a cervical smear performed and that specific follow-up was required". Dr Maplesden said that "[g]iven the report recommended colposcopy referral, which [Dr A] would have had to organise, it is somewhat puzzling that he would leave follow-up in the hands of nursing staff in the first instance".

79. In conclusion, Dr Maplesden stated:

> "It is not possible for me to determine whether [Dr A's] 'assumptions' regarding handling of cervical smear results are indicative of a sub-optimal orientation process, but I think it is common knowledge and accepted practice that providers are ultimately responsible for ensuring appropriate management of results from tests ordered by themselves, and [Dr A] failed to do this. Under the circumstances (possible misinterpretation of practice processes) this was a moderate departure from expected practice, although exacerbated by some missed opportunities for earlier communication with [Ms B] …"

80. I accept Dr Maplesden's advice. In my view, while Dr A may have mistakenly been under the impression that the nurses action all such results, it was still his responsibility to establish that the cervical smear test he had ordered had been followed up in a timely and appropriate way. I am critical that he did not do so. I note that Dr A has accepted that he should have checked on Ms B's test results a few weeks after her cervical smear, and has made changes to his practice following these events.

Referral for colposcopy

81. NCSP provides a back-up system whereby it contacts the smear taker if the relevant DHB has not notified it of having received a referral. On 5 December 2013, a co-ordinator from NCSP contacted Medical Centre 1 to enquire whether Ms B's colposcopy referral had been made. On the same day, Medical Centre 1 sent an electronic task reminder to RN D at Medical Centre 2 asking her to alert Dr A to the abnormal result to ensure that Ms B was referred for a colposcopy. On Friday 6 December 2013 RN D was on leave.

82. On Tuesday 10 December 2013, RN D sent the following urgent message to Dr A: "Task: pls refer pt to colposcopy clinic — thanks." Dr A received the message on that day and referred Ms B to the Colposcopy Clinic. He wrote on the referral:

> "[Ms B] was recently seen and had a cervical screening with CIN1 and HPV+. I am sending this to you."

83. Dr A did not review Ms B's clinical notes, and no contact was made with Ms B at that time.

84. Dr A said that because he acted on the referral urgently, he referred Ms B without checking her records or speaking to her. Furthermore, Dr A said he did not recognise that he had undertaken the smear on Ms B, assuming it had been carried out by a nurse, and that he was just being asked to do the referral. Dr A said he also assumed that the nurses would notify Ms B of the results of her smear and the referral. Dr Maplesden advised that he was "critical that [Dr A] did not review [Ms B's] notes prior to making the referral (Was she symptomatic? What was her previous smear history etc). This was a missed opportunity to realise his initial oversight …"

85. I agree with Dr Maplesden. Regardless of Dr A's mistaken assumption and misunderstanding about the process, Dr A failed to do the basics in that he did not review Ms B's clinical notes prior to making the colposcopy referral. Had he reviewed the medical notes before making the referral, he would have realised that Ms B had not been advised of her abnormal smear result.

Information not provided to Ms B

86. In addition, Dr A also failed to discuss the abnormal smear result and the colposcopy referral with Ms B. Dr A told HDC:

> "I recognise that I should have at least called [Ms B] to discuss the referral. That would not only have given her an opportunity to be told of the result, but it would also have been the time to talk to her about her preferences for either private or public referral."

87. Dr Maplesden advised that he was critical that Dr A did not discuss the colposcopy referral with Ms B, including whether she would prefer private or public referral, and said that Dr A's "management in this regard I think would be regarded with moderate disapproval by my peers".

88. I accept Dr Maplesden's advice and I consider that information about the abnormal smear result and the colposcopy referral was information that a reasonable consumer, in Ms B's circumstances, would expect to receive.

Conclusion

89. While Dr A may have mistakenly been under the impression that the nurses actioned all smear results, it was still his responsibility to establish that the cervical smear test he ordered had been followed up in a timely and appropriate way. By failing to do so, and by failing to review Ms B's clinical notes prior to making the colposcopy referral, Dr A did not provide services to Ms B with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

90. In addition, Dr A failed to ensure that he discussed the abnormal smear result with Ms B, including the need for a colposcopy referral and her preferences regarding that referral (private or public). This was information that a reasonable consumer, in that consumer's circumstances, would expect to receive. Accordingly, Dr A breached Right 6(1) of the Code.

Opinion: The Company — Adverse comment

91. The Company is a healthcare provider and an employing authority for the purposes of the Health and Disability Commissioner Act. As such, it may be held directly liable for the inadequate services provided to Ms B, and it may also be held vicariously liable for any actions or omissions of its employees and/or agents who have been found to be in breach of the Code.

Orientation of Dr A

92. Dr A told HDC that prior to starting practice, he had numerous people orienting him on various topics and protocols over several hours. He said:

> "When it came to the topic of smears, I was … told that the doctors routinely didn't do the smears and that there were specific nurses that took care of that. The person at the time told me that I didn't have to worry about the smears at all, and that these nurses did everything including all the follow up for them."

93. Dr A said that these events have shown him that "what was trying to be communicated to me at the time was not what I was hearing". Furthermore, he said: "I wasn't familiar enough with the system to know that the results would never be seen by them, and that it would only be filed back into our office Medtech system going into my 'inbox' alone."

94. I note that The Company, on the other hand, stated that its policy was that individual providers were responsible for management of results from all tests ordered by them (including cervical smears). This included ensuring that results were notified to the patient in an appropriate manner (whether by themselves or passed on with instructions to another staff member to undertake), and that any clinical follow-up indicated was undertaken in a timely and appropriate fashion.

95. While Dr A's orientation paperwork records that he was orientated about "results tracking", there is no documentation on what he was told at the time. I note that The Company said that it "cannot explain why [Dr A] expected that the nurses would be aware of [Ms B's] test result, other than that, during his orientation, he misunderstood the role nurses working for [The Company] have with regard to performing cervical smears and managing the results of those smears".

96. As I state above, I am unable to make a finding as to what Dr A was or was not told about smear taking and results tracking during his orientation.

97. Following these events, The Company took several steps to improve how the practice and its staff handle test results (as outlined above at paragraphs 62 and 63). Dr Maplesden's advice is that the changes made by The Company at both an individual staff and practice level, to optimise the handling of results, appear appropriate. I accept this advice.

98. While I am unable to make a finding as to what Dr A was or was not told about smear taking and results tracking during his orientation, Dr A appears to have misunderstood what was expected of him in this area. I am therefore critical that The Company did not ensure that Dr A had an adequate understanding of its processes in relation to results tracking and, in particular, its Patient Test Results Guideline.

Management of Ms B's complaint

99. On 24 June 2014, Ms B complained about these events directly to Medical Centre 2. She spoke to RN F.

100. RN F recorded the complaint in Medical Centre 2's electronic PMS, and sent a copy to the Practice and Nurse Manager, Ms C.

101. On 25 June 2014, Ms B emailed a formal complaint directly to Ms C. Ms C rang Ms B on or about 26 June 2014 to apologise, and advised her that the complaint would be investigated. Ms C told Ms B that she would hear back regarding her complaint within 20 working days. However, when Ms B did not hear from the practice within the 20 working days she made a complaint directly to HDC.

102. Other than RN F's recording of the complaint, nothing further was documented at the time regarding how the complaint was managed.

103. Ms C said that after receiving Ms B's complaint, she reviewed Ms B's medical notes and the electronic inboxes, which showed that there had not been "any system breakdown in our receipt of the test result". Ms C said that she concluded that the result had been overlooked by Dr A in October. However, she did not convey this to Ms B at the time.

104. Ms C said that she considered Ms B's complaint very seriously and apologises for "not managing her complaint in the manner it deserved".

105. Ms C also said: "In order to improve my process of complaint management and prevent a repeat of this situation, I have now developed a system of scheduling response dates and setting reminders in my electronic calendar as well as noting them in my diary notebook."

106. While I note the changes Ms C has made to her practice regarding complaint management, I am critical that after Ms B made a complaint and was advised that it would be investigated, she heard nothing more from The Company.

Recommendations

107. I recommend that Dr A:

a) Provide a written apology to Ms B. This should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms B.

b) Provide evidence to this Office of the subsequent changes he has advised HDC he has made to his practice following these events, within three weeks of the date of this opinion.

c) Undertake a random audit of his clinical records to ensure that patient test results received in the last two years have been followed up appropriately and communicated to patients. Dr A should provide evidence of this audit and its outcome within three months of the date of this opinion.

108. I recommend that The Company:

a) Provide a written apology to Ms B, in relation to its handling of her complaint. This should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms B.

b) Audit clinical staff compliance with requirements for management and communication of results to avoid a repeat of the scenario outlined in this report. The audit is to be conducted over a three month period with a report of the results and actions taken in response provided to this Office within six months of the date of this opinion.

Follow-up actions

109. A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr A's name.

110. A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from GP Dr David Maplesden:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Ms B]; response from [Dr A]; internal investigation report [The Company]; [The Company] GP notes.

2. [Ms B] states she had a routine cervical smear and STI screen performed by [Dr A] at [Medical Centre 2] on 11 October 2013. She states she never received any notification regarding the result or that a referral for further investigation had been made until she received a call from [the public hospital] around 22 June 2014 informing her she had an appointment at the DHB colposcopy clinic the next day. She underwent colposcopy and biopsy of a cervical lesion at [the public hospital] on 23 June 2014 and on 24 June 2014 she contacted [Medical Centre 2] to express her concern at the apparent communication breakdown, noting she would have used her health insurance to be seen promptly had she been made aware in October 2013 that she had a possible cervical abnormality. [Ms B] complains also that she received no feedback from [Medical Centre 2] regarding her complaint.

3. GP notes review/responses

(i) 11 October 2013 — [Ms B] seen for routine cervical smear and STI check (asymptomatic). Results available from the National Cervical Screening Programme (NCSP) do not record any previous abnormal smear results, with the most recent smear being July 2010. Examination and procedures were undertaken by [Dr A]. STI screening results (all normal) were received on 14 and 15 October 2013. Cervical smear result was received into [Dr A's] in-box 0707hrs 19 October 2013. There is a provider comment attached to the result indicating colposcopy referral would be required but it is not possible to determine when this comment was added, and subsequent events indicate this was likely a retrospective comment made in December 2013 (see below).

Comment: The cervical smear and STI screen were undertaken in a clinically appropriate manner. The standard of clinical documentation was adequate.

(ii) The cervical smear result was abnormal: *There are abnormal squamous cells present consistent with a low grade squamous intraepithelial lesion … positive for* [high risk HPV type] *… Referral for colposcopy is indicated due to positive HrHPV result.* [Dr A] viewed the smear result on its arrival and thinks it is likely he filed the result without actioning it specifically as he was under the impression nurses actioned all such results, including patient notification. This belief arose because a vast majority of smears were undertaken by nursing staff who also undertook follow-up of the results. However, according to the practice manager ([Ms C]), the practice policy was that individual providers were responsible for management of results from all tests ordered by them (including cervical smears). This included ensuring results were notified to the patient in an appropriate manner (whether by themselves or passed on with instructions to another staff member to undertake) and that any follow-up indicated clinically was undertaken

in a timely and appropriate fashion. Nurse smear takers were required to manage the results from smears they undertook but would communicate with the patient's GP if specialist referral was required.

Comment: Expected follow-up of the result received by [Dr A] would have been prompt notification of the result to the patient explaining the nature and implications of the result, discussion of management options (private vs public referral) and provision of a referral letter to the appropriate service provider, together with a smear recall entered into the PMS at an appropriate interval. It appears [Dr A] filed [Ms B's] result without undertaking the expected actions either as a result of human error (an intention to action the result appropriately but instead filing it by mistake) or because he was under the erroneous impression nursing staff had also received a copy of the result and would action it (including notification of the patient). However, unless [Dr A] had requested a copy of the result go to nursing staff (which he evidently had not) or that he sent the result to the nursing e-clipboard rather than filing it (which he did not) it was unlikely nursing staff would be aware [Ms B] had had a cervical smear performed and that specific follow-up was required. Given the report recommended colposcopy referral, which [Dr A] would have had to organize, it is somewhat puzzling that he would leave follow-up in the hands of nursing staff in the first instance. It is not possible for me to determine whether [Dr A's] 'assumptions' regarding handling of cervical smear results are indicative of a sub-optimal orientation process, but I think it is common knowledge and accepted practice that providers are ultimately responsible for ensuring appropriate management of results from tests ordered by themselves[1], and [Dr A] failed to do this. Under the circumstances (possible misinterpretation of practice processes) this was a moderate departure from expected practice, although exacerbated by some missed opportunities for earlier communication with [Ms B] as discussed below.

(iii) On 5 December 2013 [Medical Centre 1] staff received a call from the NCSP: [*Ms E] from Cervical Screening phoned re [Ms B's] recent abnormal cervical smear result — CIN1 1 HPV+. [Ms E] advises [Ms B] needs referring to colposcopy.* Electronic task reminders were then sent between staff (including [Dr A]) to ensure a referral was completed, but no contact was made with [Ms B]. On 10 December 2013 [Dr A] states he received the task to refer [Ms B] for colposcopy and he made a referral to [the public hospital] without consulting the notes, and not recognizing he had undertaken the smear on [Ms B] (he assumed it had been done by a nurse).

Comment: Following communication between [Ms C] of [Medical Centre 1] and NCSP staff, it was confirmed the usual practice from NCSP is that significantly abnormal smear results are notified to the patient by them in a letter generated about a month after the result has been received. While NCSP recognizes the responsibility to notify the result lies primarily with the smear taker, this service is provided as a 'back-up' in case the primary care system fails. Unfortunately, on this occasion no result letter was generated due to a technical fault (since recognized and remedied). However, a second NCSP 'back-up' system involves

[1] St George IM 2013. The management of clinical investigations. Chapter 14 in: St George IM (ed.). Cole's Medical Practice in New Zealand, 12th edition. Medical Council of New Zealand, Wellington.

contacting the smear taker if it is apparent recommended follow-up (in this case colposcopy referral) has not been undertaken within a reasonable timeframe (NCSP receive notification of receipt by DHBs of referrals for colposcopy) and this system resulted in the call to [Medical Centre 1] on 5 December 2013 to ensure colposcopy referral had been made. While [The Company] staff (including [Dr A]) then undertook to provide a referral in a timely manner I am critical that no staff involved thought to contact [Ms B] to discuss the 'late' referral even if they assumed she was aware of her result, and I am particularly critical that [Dr A] did not review [Ms B's] notes prior to making the referral (Was she symptomatic? What was her previous smear history etc). This was a missed opportunity to realize his initial oversight and also to discuss with [Ms B] whether she would prefer private or public referral. Management in this regard I think would be regarded with moderate disapproval by my peers.

(iv) [The DHB] confirmed [Ms B] was sent notification on 24 December 2013 (to her usual address) that a referral had been received for the colposcopy clinic and she would be notified with an appointment time in due course. [Ms B] does not state she received such notification. DHB staff stated usual practice would be that the patient then received a letter confirming the appointment time about two to three weeks prior to the scheduled appointment although they could not confirm such a letter was sent to [Ms B] on this occasion. [Ms B] implies she received no notification of the appointment until just before the scheduled date. She underwent colposcopy and biopsy on 23 June 2014 with histology confirming a low-grade lesion.

4. [Dr A] has outlined in his response changes he has made to his practice since the events in question and these are appropriate. [Ms C] has outlined changes made at an individual staff and practice level to optimize handling of results and these too appear appropriate. I recommend the practice provide copies of any written policies they have in relation to handling of results in general and cervical smears results/recalls in particular for the Commissioner to review. I note the complaint was handled in a sub-optimal manner with respect to timely response to the complainant and [Ms C] has discussed reasons for this in her response. While the events in question did not result in a severe outcome for [Ms B], there was certainly potential for harm under other circumstances (eg if NCSP, with their additional backup systems, had not been involved). This case illustrates the importance of having robust processes in place for tracking of results/referrals that might be anticipated to have an abnormal outcome, noting [Ms B's] consultation was for routine screening, but acknowledging it is all too easy to inadvertently file an abnormal result even when this is not the conscious intention."