Dr B, General Practitioner

A General Practice

A Report by the

Health and Disability Commissioner

(Case 12HDC01483)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive Summary

1. In May 2008, Mrs A attended her general practice (the practice) presenting with bowel symptoms including diarrhoea and rectal bleeding. She had a consultation with her usual general practitioner (GP), Dr B, who prescribed medication to help with what she concluded was Irritable Bowel Syndrome. Dr B did not undertake a digital rectal examination (DRE) at that consultation.

2. Over the next four years Mrs A saw Dr B several more times for a variety of issues. The clinical notes record that Mrs A complained of her continuing bowel symptoms to Dr B on at least two further occasions, in August 2009 and March 2012.

3. In August 2012 Mrs A requested an appointment with another GP at the practice as she felt that her bowel symptoms had not been adequately addressed by Dr B. Dr C referred Mrs A to a local general surgeon for specialist review of her persistent symptoms. Mrs A was subsequently diagnosed with advanced bowel cancer.

Dr B

4. There were failings in the care Dr B provided to Mrs A over this period. Dr B should have performed a DRE in May 2008 when Mrs A first presented with bowel symptoms. Dr B also should have ensured, over the course of the next four years, that there was a management plan in place to monitor and address Mrs A's persisting symptoms. Additionally, Dr B did not sufficiently investigate alternative diagnoses over the four years, despite indications contrary to a diagnosis of Irritable Bowel Syndrome. The Commissioner found that Dr B therefore failed to provide services to Mrs A with reasonable care and skill and so breached Right 4(1) of the Code of Health and Disability Services Consumers Rights (the Code).[1]

5. In addition, the Commissioner noted that GPs should be very aware of the need to ensure their patients feel heard and understood. The Commissioner also commented on the importance of comprehensive consultation notes.

The practice

6. The Commissioner found that the practice did not breach the Code. However, the Commissioner noted the importance of GPs having strategies in place to ensure good communication with patients who present with multiple issues at a single consultation. It is essential that patients feel they have been heard and understood and that the issues of concern to them have been addressed.

Dr C

7. Finally, the Commissioner noted that, when Mrs A presented to Dr C in August 2012 with persisting bowel symptoms, it would have been prudent for him to check whether and how those symptoms had previously been addressed at the practice.

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

Complaint and investigation

8. The Health and Disability Commissioner received a complaint from Mrs A about the services provided to her by her general practitioner, Dr B. An investigation was commenced on 18 April 2013, with the following issues identified for investigation:

- *Whether Dr B provided services of an appropriate standard in relation to the investigation and diagnosis of Mrs A's colorectal cancer between May 2008 and September 2012.*
- *Whether the practice provided services of an appropriate standard in relation to the investigation and diagnosis of Mrs A's colorectal cancer between May 2008 and September 2012.*

9. The parties directly involved in the investigation were:

Mrs A	Consumer/Complainant
Dr B	General Practitioner/Provider
The practice	General Medical Practice/Provider
Dr C	General Practitioner

10. Information from all of these parties was reviewed during the investigation.

11. Independent expert advice was obtained from the Commissioner's in-house clinical advisor, Dr David Maplesden. This advice is attached as **Appendix A**.

Information gathered during investigation

Background

12. The practice is a two-doctor general medical practice. Dr C is the principal in the practice and works full-time, while Dr B works part-time as an associate.[2] The practice also employs three registered nurses and a receptionist.

13. Mrs A had been a patient at the practice since 1998.

6 May 2008

14. On 6 May 2008, Mrs A consulted Dr B about recent changes to her bowel health. At that time, Mrs A was 49 years old, otherwise healthy, and on no regular medications. This was the first time that Mrs A had consulted Dr B about bowel symptoms. She had no personal or family history of serious bowel illness or bowel cancer.

15. Mrs A recalls telling Dr B that she had been suffering from "strange bowel habits" including diarrhoea, and blood and mucus in her stools. Mrs A was weighed (61kg) and her blood pressure was taken. Dr B's clinical notes for the consultation record:

[2] Dr C advised that he engages Dr B as an "independent contractor".

> "diarrhoea on and off for a few weeks, worst in morning — explosive, no blood except what she usually has on paper from haemorrhoids
>
> lots of gas, lot of stress, not going at night, sleeping well, feels it is IBS related to stress
>
> not painful
>
> father has similar thing when stressed
>
> […]
>
> O/E wt stable, tongue healthy, abdo slim and soft, treat as IBS/stress — review in 5 weeks with smear as well unless gets worse or anything nasty in faeces sample"

16. Dr B recalls Mrs A advising that there had been some rectal bleeding, but that it was no more than what she had experienced previously with haemorrhoids, which she had suffered from "since childbirth". There is no record of Mrs A having experienced any abdominal pain associated with the above symptoms. Dr B advised HDC that she organised for a faeces sample to be taken, but did not conduct a digital rectal examination (DRE) at the consultation.

17. Dr B diagnosed Irritable Bowel Syndrome (IBS) which she considered had been brought on by stress. The clinical notes state that she prescribed Amitriptyline[3] which can be used to settle IBS symptoms. The clinical notes from this consultation record that Dr B planned to review Mrs A in five weeks' time. Dr B advises that this review was planned for the same time as Mrs A was due to have a cervical smear test.

18. Dr B told HDC that, in hindsight, she should have performed a DRE and anal examination during the consultation on 6 May 2008. At the time, however, she considered that doing the DRE and anal examination at the same time as the smear "seemed a sensible and kind thing to do". Dr B advised HDC that she now considered that this had been an "error of judgement".

19. In response to Mrs A's complaint, Dr C told HDC that:

> "…Often patients self-diagnose haemorrhoids, either from fresh rectal bleeding or a lump at the anus. Although ideally we should inspect the anus and perform a rectal examination to confirm the diagnosis, I must admit that for various reasons this isn't always done by me if the symptoms are typical of haemorrhoids, and the risk of more serious pathology is perceived to be low."

20. Mrs A recalls being told by Dr B at this consultation that the problem was not IBS, but was probably haemorrhoids. She noted that Dr B did not examine her for haemorrhoids, or prescribe any treatment for this. Mrs A felt that her concerns were "fobbed off" by Dr B at this consultation. Mrs A does not recall any follow up

[3] Amitriptyline is an antidepressant with sedative properties. My expert advisor, Dr David Maplesden, advises that it is commonly used to treat chronic pain, syndromes such as IBS, and to help with sleep.

consultation being arranged or that Dr B said she would review Mrs A's bowel symptoms at a later date.

21. In response to the information gathered section of my provisional opinion, Mrs A clarified that she does not believe she has ever had haemorrhoids, or sought or received treatment for haemorrhoids. She therefore does not believe she would have told Dr B that she had a history of haemorrhoids.

Follow-up

22. Mrs A told HDC that there was no appointment scheduled for a smear test or for review of her bowel symptoms, and that she received no reminder by letter or by telephone of any such appointment.

23. The clinical notes do not record that an appointment was scheduled for Mrs A's smear test. The practice provided HDC with a letter dated 30 September 2008 reminding Mrs A that she was overdue for a smear test. This letter is from a "practice nurse" who is not named, and the practice's records do not record whether this letter was sent. The practice's records do show that a letter was sent to Mrs A on 15 January 2009, reminding her that she was overdue for a cervical smear.

24. Dr B did not review Mrs A in five weeks' time. Dr B told HDC that, "when [Mrs A] chose not to attend for that follow-up, I would have assumed the bowel symptoms were no longer bothering her". Mrs A's faeces sample came back normal with no infection, parasites, white or red cells found. Dr B advised HDC that, because the results were normal, she would not have contacted Mrs A to let her know the test results.

25. Mrs A had her cervical smear test performed at a specialist clinic in February 2009 and did not return to the practice until April that year, when she saw Dr C about an ulcer in her mouth. There is no mention of any bowel symptoms in the clinical notes from this consultation.

Arm injury — June/July 2009

26. On 19 June 2009, Mrs A saw Dr B for the first time since the 6 May 2008 consultation. Mrs A had recently sustained an arm injury in a fall. She recalls telling Dr B at this appointment that she was still having trouble with her bowels, and that her symptoms had worsened. There is no mention of any bowel symptoms in the clinical notes from this consultation. Mrs A was weighed (63 kg) and her blood pressure was taken.

27. On 29 June 2009, Mrs A again saw Dr B about her arm pain, and then on 15 July 2009, saw Dr C for the same reason. There is no mention of any bowel symptoms in the clinical notes from either of these consultations.

3 August 2009

28. On 3 August 2009, Mrs A had another consultation with Dr B. Mrs A recalls that she went to Dr B because she was still having bowel problems. However, Dr B recalls that Mrs A's primary concern was her continuing arm pain, but that they also discussed her bowel symptoms. The clinical notes for this consultation read:

> "thinks she is making progress — less burning in forearms, finding driving better, tried a few more jobs at home in the weekend and stirred it up a bit but is looking perkier now making progress
>
> not taking analgesia
>
> has been getting upset gut with noisy wind and diarrhoea about once a fortnight
>
> father has similar gut but no hx polyps no ca
>
> hx is that it came on first with financial stress, did settle with amitrip, no bloods no mucous
>
> check FOBs"

29. Mrs A recalls asking Dr B about having a colonoscopy performed, but that this request was "fobbed off". Mrs A told HDC that she requested a colonoscopy "for [her] own peace of mind" and that Dr B told her that colonoscopies were not done for "peace of mind".

30. Dr B does not recall Mrs A asking for a colonoscopy, but told HDC that she would have taken such a request seriously and "tried to find reasons to justify it". Dr B informed HDC that she believes that, at the time of this consultation, it would have been unlikely that Mrs A would have been accepted for a colonoscopy. This was because Mrs A had no family history of bowel cancer, no recent history of blood or mucous in her stools, and an ongoing (rather than new) history of changeable bowel motions.

31. Dr B did not perform an abdominal examination at this consultation, but did organise for a faeces sample to be taken and a faecal occult blood test (FOB) to be performed.[4] The FOB test returned a negative (normal) result.

32. Mrs A told HDC that after this consultation she:

> "…went home feeling unheard and decided that I just had to get on with life and that my issues were 'all in my head'. I was still being prescribed Amitriptyline because [Dr B] said it would settle the bowel problem and help with sleep. I continued this regime because I felt that my problem was being treated as psychological I was reluctant to go back to my Doctor [sic]."

September 2009

33. On 7 September 2009 Mrs A saw a locum GP at the practice about her arm pain.

34. On 29 September 2009 Mrs A saw Dr B. The clinical notes from this consultation suggest that Mrs A's arm pain and difficulty sleeping were discussed, but that bowel symptoms were not mentioned. Dr B prescribed further Amitriptyline to help with Mrs A's sleep and to reduce her arm pain.

[4] A test for the presence of microscopic amounts of blood in the faeces. A positive test result indicates there is bleeding in the digestive tract.

2010 and 2011

35. There is no record of Mrs A visiting the practice at any time during 2010 and 2011. Between January and July 2010 she was provided with three repeat prescriptions for Amitriptyline over the phone. The clinical notes indicate that these prescriptions were signed by Dr B. Dr B told HDC that telephone requests for repeat prescriptions are usually made to a practice nurse, and do not involve a conversation with a doctor (though the doctor checks and signs the prescription). Dr B explained that the practice usually asks patients to come in for a consultation for every second prescription, and that second and third repeats are only provided over the telephone when the patient "insists they are fine using the medication" and there is some reason why they cannot come in for a consultation. Dr B advised HDC that:

> "I assume we thought [Mrs A] was happy using the [A]mitriptyline for help with sleep, arm pain and bowel control and we were giving the telephone prescription because she lived in the country."

13 March 2012

36. On 13 March 2012, Mrs A had another consultation with Dr B. At this consultation a cervical smear was performed. Mrs A was also reminded about her overdue mammogram, and was given a referral to a dermatologist to check a skin lesion on her lip. Mrs A was weighed (60kg) and her blood pressure was taken. Mrs A also brought up her continuing bowel symptoms.

37. The clinical notes for this consultation record, regarding Mrs A's bowel symptoms, that:

> "[…] Chronic history of bowel upset — occasionally mucous, often loose, one episode black mucky stuff with mucous after pain in tail bone for a few days — pain cleared with the passage of this stuff
>
> No FH of bowel ca
>
> abdo soft — skin around anus a bit atrophic
>
> plan — check basic bloods — for absorption and faeces for FOBs then review"

38. Mrs A recalls that by this stage she was very concerned about her continuing bowel problems. She advised HDC that she told Dr B at this consultation that she could "feel something in [her] bowel area".

39. Dr B advised HDC that she was concerned by Mrs A's description of passing "black stuff and mucous". Dr B does not recall whether she performed a DRE at this consultation. She informed HDC that, as her notes indicate that she performed a visual examination of Mrs A's anus, she believes that she probably did perform a DRE. However, as the notes do not record this, Dr B accepts that she may not have performed a DRE. In her response to the information gathered section of my provisional opinion, Mrs A stated that Dr B did not perform a DRE at this consultation.

40. Dr B again organised a FOB test. Blood tests were organised to assess whether Mrs A had an iron deficiency (which could indicate blood loss). All test results were normal.

41. Mrs A recalls being sent for blood tests and being told that "they" would contact her if anything showed up. As she did not hear from the practice about the results, she was "left feeling that I was over-reacting".

42. In her response to the information gathered section of my provisional opinion, Mrs A also stated that she was "made to feel like an over-reacting menopausal woman treated with [Amitriptyline] for a psychological reason".

43. Dr B told HDC that, because of the number of issues that needed to be covered at this consultation, she should have scheduled another time to deal with the bowel symptoms:

> "It was unrealistic of me to expect to do the cervical smear, give advice (which involved a referral to a skin specialist) about one problem and then give full attention to what in hindsight turned out to be the most important problem of them all."

44. Dr C was of the view that:

> "Although in no way wishing to blame [Mrs A], I must say that consultations are significantly more difficult and time consuming, when all the issues to be dealt with are not declared at the beginning of the consultation. [Mrs A] would sometimes have several problems to be dealt with during the one consultation, but would not indicate this at the outset… I admit that if a potentially serious problem is declared towards the end of the consultation, this should still be dealt with properly, but this behaviour does make the life of a busy GP more difficult."

21 August 2012

45. On 21 August 2012 Mrs A returned to the practice. She recalls that she specifically asked to see Dr C, rather than Dr B. At this consultation Mrs A was weighed (63.5kg) and her blood pressure taken. She had hurt her shoulder in a fall three weeks previously, and Dr C examined her and referred her to a physiotherapist. Dr C recalls that this injury was the primary reason for Mrs A attending, but that Mrs A did mention her bowel problems later in the consultation. The clinical notes for this consultation record:

> "[…]2. bowels erratic for a couple of years, although better lately since taking cherry syrup (from health food shop) for insomnia (works well), but episodes of rectal bleeding, fresh blood after BM's, occ faecal urgency, sometimes mucous with motions, painful 'tail bone' at times.[…]"

46. Dr C also performed a DRE at this stage and no rectal mass was detected.[5]

[5] Though not reflected in the clinical notes, this finding is recorded in Dr C's referral letter to the local general surgeon.

47. In her response to Mrs A's complaint, Dr B noted that Mrs A's description of her rectal bleeding, as recorded in Dr C's notes of this consultation ("fresh blood after BM's") was "completely different" to how Mrs A had described the bleeding to Dr B on 6 May 2008, which Dr B's notes record as "what she usually has on paper from haemorrhoids".

48. Dr C referred Mrs A to a local general surgeon for review. Dr C told HDC that at that stage, he was not aware that Mrs A had attended Dr B previously about her bowel symptoms. Dr C advised that, when he referred Mrs A, he "fully expected [the general surgeon] to find a rectal outlet cause of the bleeding, rather than a more serious cause".

Diagnosis

49. On or around 11 September 2012, Mrs A spoke to Dr C and informed him that she had been diagnosed with advanced bowel cancer. At that time Mrs A expressed her dissatisfaction that her bowel symptoms had not been appropriately addressed by Dr B.

50. Following her diagnosis, Mrs A requested her medical notes from the practice. Mrs A told HDC that she felt Dr B's notes were "incomplete" and that several issues she raised during various appointments had not been recorded. For example, Mrs A recalls raising concerns about her bowel symptoms at various consultations where the clinical notes do not record this.

51. Dr B stated that she does not agree that her notes were incomplete. She advised that, while it is impossible to record everything said in a consultation, she "[tries] to record the symptoms of what a patient says is the problem".

Changes to practice

52. Dr B told HDC that when she became aware of Mrs A's diagnosis, she reflected on her treatment of Mrs A and initiated changes in her practice. Dr B stated that she:

- reviewed her treatment of Mrs A with a group of her peers and has become "more aware of the possibility of cancer in many patients";
- now examines the abdomen and performs DREs more often with patients with bowel symptoms; and
- now uses the recall facility on her computer system to call a patient after several weeks to follow up with them if she has any concerns about the symptoms that they presented with.

53. Dr B told HDC that she:

- is "really sorry [Mrs A] found [Dr B's] manner dismissive";
- "wish[es] [she] had been able to diagnose [Mrs A's cancer] earlier"; and
- has tried to telephone Mrs A "to offer support" but, hearing that Mrs A would "prefer not to have contact [with Dr B]", she has not tried to contact Mrs A again.

54. Dr B also said that:

> "I am truly sorry [Mrs A] felt 'fobbed off" and have tried to think why she may have felt like that. I had no sense at the time of the consultation that she was not happy with our arrangements … when she spoke about her bowel problems again in August 2009, she denied any bleeding and said nothing to me about any ongoing problems or concerns about the consultation in May 2008."

Other relevant standards/guidelines

Guidelines — Ministry of Health/New Zealand Guidelines Group, *Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparity (2009)*[6]

"Recommendations
Colorectal cancer: urgent referral (within two weeks)

- 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. Note that a pelvic mass outside the bowel should be referred urgently to a urologist or gynaecologist. […]

- A non-menstruating woman with unexplained iron deficiency anaemia and a haemoglobin of 100g/L r below, should be referred urgently to a specialist. […]

Good practice points
Colorectal cancer: urgent referral (within two weeks)

- A person presenting with a right-sided abdominal mass, should be referred urgently for a surgical opinion. […]

Recommendations
Colorectal cancer: referral/investigation

- 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, no examinations or investigations other than an abdominal and rectal examination, and a complete blood count should be undertaken as this may delay referral. […]

[6] In his advice, Dr Maplesden notes that these guidelines were "made available to New Zealand GPs in late 2009 but predominantly reinforced expected practice prior to that time".

Good practice points
Colorectal cancer: referral/investigation

- A person at low risk of colorectal cancer with a significant symptom (rectal bleeding or change in bowel health) and a normal rectal examination, no anaemia and no abdominal mass, should be managed by a strategy of treat, watch and review in the months. […]

Opinion: Breach – Dr B

55. This investigation highlights the importance of the overall management of symptoms over a period of time, and of effective communication with patients, in order to ensure an appropriate standard of care is provided.

56. The clinical notes record that Mrs A presented to Dr B with bowel symptoms at least three times over a period of nearly four years: in May 2008, August 2009 and March 2012. There were long periods of time between some of Mrs A's consultations with Dr B. Notably, there was a two and a half year gap between August 2009 and March 2012. During that period Mrs A telephoned the practice several times to request repeat prescriptions of medication she had been prescribed for her sleep problems, bowel symptoms, and her ongoing arm pain. As a result, Dr B signed three repeat prescriptions of Amitriptyline for Mrs A over that period. Dr B told HDC that Mrs A would only have been provided with three repeat telephone prescriptions if she had indicated that she was "fine using the medication". Dr B advised that she would have therefore assumed that the medication was effective in treating Mrs A's symptoms.

57. In contrast, Mrs A stated that she had felt "fobbed off" and "unheard" by Dr B at her previous appointment (in August 2009) and had been made to feel that her concerns about her bowel symptoms were "in [her] head". Mrs A advised HDC that this was the reason she was "reluctant" to go back to Dr B. Dr B advised that she was not aware at any time that Mrs A has these concerns or what may have led to these feelings.

58. I note that my in-house clinical advisor, Dr David Maplesden, advised that Mrs A's infrequent presentation with bowel symptoms goes some way towards mitigating the failure to diagnose Mrs A's bowel cancer until it was significantly advanced.

Consultation on 6 May 2008

59. Mrs A first raised her bowel symptoms with Dr B on 6 May 2008. At that time, Mrs A's symptoms included some rectal bleeding and a change of bowel pattern. In light of Dr B's contemporaneous medical notes that record previous haemorrhoids, I find it more likely than not that Mrs A led Dr B to understand that such history existed. Dr B explained to HDC that she attributed Mrs A's rectal bleeding to haemorrhoids because Mrs A described the bleeding as similar to what she had experienced with haemorrhoids in recent years. Dr B diagnosed the change in bowel patterns as being

due to IBS. She took a faecal sample and prescribed Amitriptyline to help with Mrs A's symptoms.

60. Dr B did not undertake a DRE at this consultation. I note that Dr Maplesden is critical of this omission, stating that there was a "failure to confirm the minimal rectal bleeding could be readily attributed to persistent haemorrhoids by undertaking a DRE".

61. Dr B stated that she did not diagnose haemorrhoids with a DRE and anal examination at this consultation because she had expected to do these examinations in five weeks' time when Mrs A was due to have a smear test. Dr B accepted that, in hindsight, her failure to perform a DRE and anal examination at this consultation was an "error of judgment".

62. I consider that Dr B should have done a DRE at this consultation to satisfy herself that Mrs A's rectal bleeding could be attributed to haemorrhoids. While confirmation of haemorrhoids via a DRE would probably not have changed Dr B's management of Mrs A, if a DRE had been performed and had shown no evidence of haemorrhoids, this may have led to closer management of Mrs A's symptoms and recognition that further investigation or a specialist referral was required.

63. Dr Maplesden is also of the view that there was a failure at this consultation to consider performing a blood count to exclude anaemia, notwithstanding the fact that Mrs A did not show any signs of anaemia, even on later blood tests. Anaemia, when associated with a change in bowel patterns, can indicate a serious bowel problem requiring more detailed investigation. I consider that, as with the DRE, Dr B should have performed a blood count at this consultation as a matter of good practice.

64. Dr Maplesden also advises that there were deficiencies in Dr B's diagnosis of IBS. Specifically, he notes that Dr B failed to consider the significance of the following things in making that diagnosis:

- the absence of abdominal pain;
- Mrs A's relatively advanced age at the time of the onset of symptoms; and
- the presence of rectal bleeding.

65. Dr Maplesden notes in particular that the presence of rectal bleeding and onset of symptoms in patients over the age of 40 are regarded as "'alarm' symptom[s] in the context of diagnosing IBS, usually indicating the need for further examination".

66. In response to Dr Maplesden's advice regarding the absence of abdominal pain in the context of the IBS diagnosis, Dr B stated that she "assumed that [Mrs A's] diarrhoea was painful, especially when it was explosive".

67. Overall, Dr Maplesden considers Dr B's management of Mrs A at the 8 May 2008 consultation to have departed from expected standards to a moderate degree, even though, based on Mrs A's history and her presentation at that appointment, bowel cancer was not statistically indicated.

68. I am of the view that, even if it was unlikely that Mrs A would have been diagnosed with cancer in any event, Dr B did not adequately consider possible differential diagnoses when addressing Mrs A's symptoms at that time.

69. In coming to this conclusion, I acknowledge that Dr B expected to do a DRE when Mrs A was due to attend the practice for a smear test five weeks later. While there is conflicting evidence as to whether or not such a follow-up appointment was discussed, it is clear that no such appointment took place, with Mrs A next visiting the practice almost a year later. It is also clear that Dr B did not subsequently perform a DRE, at least not until March 2012.

Consultation on 3 August 2009

70. At the consultation on 3 August 2009 Mrs A presented with intermittent diarrhoea, an apparently positive response to the Amitriptyline, and no weight loss. Dr Maplesden advises me that these factors, together with the negative results of the FOB test that Dr B ordered, supported the diagnosis of IBS, although the atypical absence of adnominal pain still appears not to have been considered.

71. Mrs A stated that, at this consultation, she discussed undergoing a colonoscopy for her "own peace of mind" and that she felt this request was "fobbed off" by Dr B. Mrs A also said that she felt "unheard … and that [her] issues were 'all in [her] head'".

72. The clinical notes do not record a discussion about having a colonoscopy. Dr B told HDC that she does not remember discussing a colonoscopy with Mrs A, but would have taken such a discussion seriously and "tried to find reasons to justify it". Dr B also stated that it would have been unlikely that Mrs A's symptoms at that time would have been serious enough to meet the threshold required for such a referral.

73. However, even if referral for a colonoscopy was not realistic at that time or was not discussed, the consultation would have been a good opportunity to undertake a repeat abdominal examination, a blood count, blood tests, and to organise further review. I note that Dr B did organise a FOB test, which returned normal results. Nonetheless, there appears to have been no structured management or follow-up plan put in place to monitor Mrs A's persistent symptoms.

Consultation on 13 March 2012

74. On 13 March 2012 Mrs A raised several health issues with Dr B, including her bowel symptoms. The clinical notes from this consultation refer to a "chronic history of bowel upset". Dr B organised a blood test and a FOB test. The clinical notes record that Dr B's clinical plan was to "check basic bloods … then review". As it was not Dr B's (or the practice's) usual practice to notify patients of normal results, Mrs A was not informed of her test results.

75. Dr Maplesden states that he is "mildly to moderately critical" of Dr B's management at this consultation. He notes that there is no evidence that the issues that should have been considered at the initial diagnosis of IBS nearly four years earlier[7] were followed

[7] The presence of rectal bleeding, the relatively advanced age at the onset of symptoms and the lack of abdominal pain, as discussed above.

up at this consultation either. Furthermore, as noted by Dr Maplesden, "when investigations failed to clarify a diagnosis (or did not raise suspicion of a sinister diagnosis), there was no follow-up to actually manage the symptoms".

76. I agree that formal review of Mrs A's symptoms should have been arranged at this stage given Mrs A was, by then, suffering from a "chronic history of bowel upset". While the clinical notes do indicate that Dr B intended to review Mrs A, it is unclear whether the importance of a review was made clear to Mrs A, or to what extent it was discussed. I note that Mrs A does not recall being asked to return to the practice for review.

77. While it will not usually be necessary for a general practitioner to contact patients to advise of normal test results, in this case contacting Mrs A upon receipt of the results may have provided a good opportunity for discussion about further follow-up and symptom management.

Conclusion

78. Mrs A presented to Dr B with bowel symptoms on at least three occasions over a period of nearly four years.

79. I am of the view that, over that time, Dr B missed several opportunities to further investigate Mrs A's ongoing bowel symptoms or to implement a plan to do so. In May 2008, Dr B did not perform a DRE or take other steps to assure herself that Mrs A's rectal bleeding was due to haemorrhoids. This is particularly concerning in the context of a patient over the age of 40 reporting a change in bowel activity.

80. From May 2008 until March 2012, Dr B proceeded with a working diagnosis of IBS and there is no evidence that she adequately considered several relevant clinical factors that may have changed that diagnosis or suggested a possible differential diagnosis.

81. It appears that at no point did Dr B organise for adequate follow up for Mrs A even when, by March 2012, Mrs A had a "chronic history of bowel upset".

82. I recognise that there were several factors that mitigated the above shortcomings, namely that Mrs A presented relatively infrequently, she was at a low risk of bowel cancer, and that for a time medication prescribed on the basis of a diagnosis of IBS seemed to be effective. Nevertheless, I am of the view that Dr B did not provide services to Mrs A with appropriate care and skill and so breached Right 4(1) of the Code.

Opinion: Adverse comment – Dr B

83. Mrs A consistently felt "fobbed off" by Dr B. In contrast, Dr B stated that she was never aware that Mrs A felt this way about the doctor-patient relationship.

84. Had Mrs A discussed her feelings with Dr B, the relationship may have improved or Mrs A may have seen Dr B's colleague Dr C about her bowel symptoms earlier than she did. I acknowledge that it is difficult to improve on a situation if one is not aware of it.

85. However, given the amount of trust that individuals put in their GPs, it is very important for GPs to facilitate effective communication. GPs should be very aware of the need to ensure their patients feel heard and understood, and that issues which concern them have been addressed.

86. I note Dr C's comment that consultations involving multiple issues can be difficult for busy general practitioners. Nonetheless, I expect it to be well within the capability of all general practitioners to devise and employ effective strategies to deal with such situations. As Dr B noted, at Mrs A's consultation in March 2012, she should have scheduled another time to deal with any issues that she felt she did not have sufficient time to adequately address. By not doing so, Dr B increased the likelihood of missing important issues and may have contributed to Mrs A's feeling of being "fobbed off".

Opinion: Other comment – Dr B

Record keeping

87. I note Mrs A's concern that some of the issues that she raised with Dr B were not recorded in her clinical notes. For example, Mrs A asserts that she raised her bowel symptoms at various appointments where Dr B's notes do not record this. Similarly, Mrs A is adamant that a colonoscopy was discussed in August 2009, but this is not documented in the clinical notes.

88. In contrast, Dr B told HDC that she does not believe her notes are incomplete and that, while she cannot record everything that is said, she tries to record "the symptoms of what a patient says is the problem".

89. I do not consider it is necessary for me to make a factual finding on this point. I note, however, as I have previously stated, that the importance of good record keeping cannot be overstated.[8] This includes the need for consultation notes to be comprehensive.[9]

90. Dr Maplesden has advised me that, in general, the standard of Dr B's documentation was good. I note that her references to "review" in the records of the consultations in May 2008 and March 2012 are ambiguous but that, in general, her clinical notes of her consultations with Mrs A appear to be extensive.

[8] Opinion 10HDC00610 at page 10.
[9] Hill, A., "Systems, Patients, and Recurring Themes" *New Zealand Doctor* (9 March 2011). Available at: www.hdc.org.nz.

Opinion: No breach – The practice

91. Dr B's failures in her care and management of Mrs A's bowel symptoms were matters of individual clinical judgment. Mrs A was appropriately referred when she raised her bowel symptoms with another GP at the practice, Dr C. There is no evidence that the practice's policies or practices contributed to Dr B's errors of judgment and therefore I do not find that the practice is vicariously liable for Dr B's breach of the Code, or directly liable for any breach of the Code.

Opinion: Adverse comment – Dr C

Multiple patient concerns

92. In response to this complaint Dr C stated that "consultations are significantly more difficult and time consuming, when all the issues to be dealt with are not declared at the beginning of the consultation". He noted that when patients disclose potentially serious problems at the end of a consultation, this makes "the life of a busy GP more difficult".

93. I accept that GPs deal with a large volume of patients who they see for short amount of time and that it can be a challenge to manage patients' expectations in that context. I also note that Dr C acknowledged that, even when there are many different issues to deal with, each of these should be dealt with "properly".

94. Nonetheless, Dr C's comment is unfortunate. The issue he describes is one that is common to general practice. I expect it to be well within the capability of all general practitioners to address this issue directly with a patient. General practitioners need to devise and employ effective strategies to deal with situations where patients present with many concerns at once. This may, for example, involve scheduling another time to deal with any issues that the doctor feels they have not had sufficient time to adequately address. By not having effective strategies to deal with a patient who raises multiple concerns throughout a consultation, there is a risk that the doctor will miss important issues or the patient may end up feeling as if they have not been heard.

Reviewing clinical records

95. I also note Dr C's comment that, when he referred Mrs A to a local general surgeon in August 2012, he was "not aware that [Mrs A] had attended [Dr B] previously" about her bowel symptoms.

96. This Office has previously noted the importance of reviewing patient notes on the basis that:

> "The Medical Council of New Zealand publication "Good Medical Practice: A Guide for Doctors" states that good clinical care includes adequately assessing a

patient's condition, taking account of the patient's history and his or her views and examining the patient as appropriate."[10]

97. Mrs A had been a patient at the practice since 1998 and she had first seen Dr B about her bowel symptoms in May 2008. Dr C's notes of the consultation record that Mrs A's "bowels [had been] erratic for a couple of years". In these circumstances, I consider it would have been prudent for Dr C to ask Mrs A whether she had previously sought advice about her bowel symptoms at the practice and to review Mrs A's patient notes to see whether and/or how these symptoms had been addressed previously at the practice. I am concerned that he did not do so.

98. In response to my provisional opinion, Dr C stated that after he had made the decision to refer Mrs A, he "felt that further conversation and reading of notes would not have changed [his] management in any way". While I acknowledge that Dr C's management of Mrs A in this instance was appropriate, I nonetheless remain concerned at his initial assertion that he was "not aware" that Mrs A had been seeing Dr B about her bowel symptoms. Therefore I remain of the view that, in the circumstances, it would have been appropriate for Dr C to review Mrs A's patient notes.

Recommendations

99. As per the recommendation in my provisional report, Dr B has provided a written apology to Mrs A through HDC.

100. I recommend that Dr B undertake an audit of her patients' clinical records in order to identify any patients that require follow up and have not received it.

101. I recommend that Dr B report back to this Office regarding the above audit by **4 September 2013.**

Follow-up actions

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the District Health Board and they will be advised of Dr B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[10] Opinion 09HDC01765 (15 June 2011) at page 20.

Appendix A - Independent clinical advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

"1. Thank you for providing this file for review. I have examined the available documentation: complaint from [Mrs A]; response from [Dr B]; GP notes. [Mrs A] complains that [Dr B] did not investigate her symptoms of bowel disturbance adequately leading to delay in a diagnosis of colorectal cancer (CRC). The cancer was advanced (liver metastases) when finally diagnosed in September 2012.

2. As basis for subsequent comments, I refer mainly to the Ministry of Health/New Zealand Guidelines Group publication *Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparities (2009)* which was made available to New Zealand GPs in late 2009 but predominantly reinforced expected practice prior to that time. I have listed below recommendations from that publication relevant to this case:

(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*

(ii) *A person presenting with a palpable rectal mass (intraluminal and not pelvic), should be referred urgently to a specialist, irrespective of age. Note that a pelvic mass outside the bowel should be referred urgently to a urologist or gynaecologist*

(iii) *A non-menstruating woman with unexplained iron deficiency anaemia and a haemoglobin of 100 g/L or below, should be referred urgently to a specialist*

(iv) *A person presenting with a right-sided abdominal mass, should be referred urgently for a surgical opinion* (good practice point)

(v) *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*

(vi) *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*

(vii) *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* (good practice point)

3. [Mrs A] was just under 50 years old when first seen by [Dr B] with bowel symptoms on 6 May 2008. The incidence of bowel cancer in the 50-55 age group in New Zealand is 47 per 100,000, which gives a risk of contracting the disease within

the five year period (50-55) of <0.23%[11] (low risk). [Mrs A] evidently had no history of inflammatory bowel disease or adenomatous polyps, or significant family history that might have increased her risk.

4. General review of clinical documentation shows the standard of documentation is good, expected screening examinations were undertaken and [Dr B] had previously referred [Mrs A] for specialist assessment when clinically indicated (breast lump referral October 2007, skin lesion referral March 2012).

5. At the consultation of 6 May 2008 [Dr B] recorded [Mrs A's] history of *diarrhoea on and off for weeks, worst in the morning — explosive, no blood except what she usually has on paper from haemorrhoids, lots of gas …* Symptoms appeared to be related to stress. Abdominal examination was unremarkable. No rectal examination was recorded. Diagnosis was likely irritable bowel syndrome (IBS). Faeces samples were ordered (no red or white cells, culture negative) and Amitriptyline prescribed. Follow-up was *review in five weeks with smear* (which was due about that time) *unless gets worse or anything nasty in faeces samples.* [Mrs A] did not attend for review or her smear despite reminder letters sent on 30 September 2008 and 15 January 2009. The next consultation was with [Dr C] on 15 April 2009 for a mouth lesion. A blood test was performed at this time and showed no signs of anaemia.

Comment: An important factor in this consultation was the presence of intermittent, albeit apparently minimal, rectal bleeding in association with a several week change in bowel pattern to looser stools. It is not clear when or how the diagnosis of haemorrhoids had been made (was this a self-diagnosis or a confirmed diagnosis?). The guidelines referred to in section 2 (i) suggest consideration should have been given to referring [Mrs A] for further investigation at this point noting the symptoms of rectal bleeding and change in bowel pattern to looser stools, although I am assuming the significance of the rectal bleeding was downplayed because it was a longstanding symptom attributed to haemorrhoids. There is no record of abdominal pain as a symptom – this being one of the diagnostic criteria for IBS[12]. Furthermore, the presence of rectal bleeding and age >40 years at onset of symptoms are regarded as a potential 'alarm' symptom in the context of diagnosing IBS[13], usually indicating the need for further investigation. I think there were some deficiencies in this consultation: failure to confirm the minimal rectal bleeding could be readily attributed to persistent haemorrhoids by undertaking a rectal examination; failure to consider performing a blood count to exclude anaemia as an additional 'red flag' feature associated with change in bowel pattern (although I note [Mrs A] never exhibited signs of anaemia on subsequent blood tests even at the time of her diagnosis); failure to consider the significance of absence of abdominal pain, relatively advanced age of onset at time of symptom onset and presence of rectal

[11] These and following figures from: New Zealand Guidelines Group. Surveillance for people at increased risk of colorectal cancer. 2012. Available at: *www.nzgg.org.nz/.../surveillance-increased-risk-colorectal-cancer.pdf*

[12] Wald A. Clinical manifestations and diagnosis of irritable bowel syndrome. UpToDate. Last updated December 2012

[13] Longstreth GF, Thompson WG, Chey WD, et al. Functional bowel disorders. *Gastroenterology* 2006;130:1489–1491

bleeding in the context of making a diagnosis of IBS. Mitigating factors include: [Mrs A] was at low risk for CRC; abdominal examination was normal; there was no evidence of weight loss on recorded sequential weights; the rectal blood loss was evidently perceived to be minimal, outlet type classically associated with haemorrhoids (which may have been previously demonstrated), longstanding and unchanged from usual pattern; the symptoms appeared to be stress related which was consistent with a diagnosis of IBS, and there was a family history of this pattern of bowel disturbance (functional); there was no evidence of occult blood loss on the faeces specimen obtained; there was a documented intention to follow-up [Mrs A] in a timely fashion (and one could argue this was consistent in part with the guideline recommendation in section 2 (vii) although [Dr B] had not performed a rectal examination or checked for anaemia – both investigations likely (in hindsight) to have been normal); a therapeutic trial was given for IBS. Taking all of these factors into account, I feel [Dr B's] management of [Mrs A] on this occasion departed from expected standards to a moderate degree assuming there were reasonable grounds to attribute the rectal bleeding to haemorrhoids, and noting that performing a rectal examination and blood count would most likely not have led to an immediate diagnosis but might have resulted in closer surveillance (and earlier referral) of [Mrs A] should her symptoms have persisted. However, if there were inadequate clinical grounds on which to attribute [Mrs A's] rectal bleeding to haemorrhoids (no prior clinical documentation confirming this diagnosis) I would upgrade the departure to 'moderate to severe'. In this regard, [Dr B] should be asked to clarify on what basis [Mrs A's] symptom of rectal bleeding reported at this consultation was attributed to haemorrhoids, and to provide documentary evidence the diagnosis of haemorrhoids had been previously confirmed if such information is available.

6. The next recorded consultation was 19 June 2009 ([Dr B]). [Mrs A] had not reported her persistent symptoms to a clinician since the initial consultation some 13 months previously. The extensive consultation notes refer to [Mrs A's] complaint of activity related bilateral forearm and elbow pain, and the assessment associated with this. [Dr B] does not recall [Mrs A] mentioning her bowel symptom at this consultation or any of the following consultations (29 June and 15 July 2009) at which the persistent arm symptoms were addressed. Weight was recorded and was increased from previous measurements. Blood tests were taken (regarding the arm symptoms) — there was no anaemia and inflammatory markers were normal.

7. On 3 August 2009 [Mrs A] saw [Dr B] for further review of her arm symptoms. On this occasion history of bowel symptoms was also obtained and recorded as: *has been getting upset gut with noisy wind and diarrhoea about once a fortnight, father has similar gut but no hx polyps, no ca. Hx is that it first came on with financial stress, did settle with amitrip, no bloods, no mucous. Check FOBs* [faecal occult blood testing] — three samples were negative although the standard pathologist comment is attached to each result: *The negative result does not necessarily exclude gastrointestinal bleeding. Repeat testing and/or other clinical follow-up is warranted if the suspicion of bleeding is high.* Further Amitriptyline was prescribed (used in both IBS and as a pain modulator (for [Mrs A's] persistent forearm problem)). No formal follow-up was documented. There is no record of abdominal or rectal examination being performed. However, there was a follow-up appointment on 29 September 2009

at which only the forearm symptoms were discussed (improved with use of Amitriptyline).

Comment: [Mrs A's] bowel symptoms were discussed on this occasion as part of a consultation involving unrelated symptoms. The intermittent diarrhoea had now been present for well over a year but had apparently settled when she was taking Amitriptyline. There was some documented positive change in symptoms in that absence of rectal blood or mucous is now recorded. There was no weight loss. The symptoms had evidently not been sufficiently disturbing to warrant [Mrs A] seeking medical attention for them for well over a year. The response to Amitriptyline, the intermittent nature but relative stability of the symptoms and the absence of weight loss (and subsequently the negative FOBs) were somewhat reassuring features and supportive of the working diagnosis of IBS. However, the absence of any abdominal pain symptom was atypical for that condition. I agree with [Dr B] that [Mrs A's] presentation at this time may not have met the threshold for colonoscopy at some DHBs. However, I feel at this point there was still an indication to undertaken a repeat abdominal examination (the last one having been more than a year previously), blood count to exclude anaemia, perhaps blood tests to exclude coeliac disease, and to agree a time for review of the symptoms if they persisted. The failure to do these things was a mild departure from expected standards under the circumstances.

8. [Mrs A] did not return for review for a further two and a half years even though her symptoms persisted. She states this was because she had felt 'fobbed off' by [Dr B] and had been given the impression her symptoms were not concerning. The next consultation was 13 March 2012 and was complex with [Mrs A] presenting multiple issues: request for cervical smear (undertaken by [Dr B]); check of lip lesion (referral made to skin specialist); and complaint of persistent bowel symptoms. Notes referring to the latter complaint are: *chronic history of bowel upset — occasionally mucous, often loose, one episode black mucky stuff with mucous after pain in tail bone for a few days – pain cleared with passage of this stuff. No FH of bowel ca. Abdo soft – skin around anus a bit atrophic. Plan: check basic bloods — for absorption and faeces for FOBs then review.* [Dr B] cannot recall whether or not she performed a digital rectal examination (DRE) but if she has examined the perianal area (which is recorded) her usual practice is to proceed with DRE and she thinks it is likely she did so on this occasion. Blood test (11 April 2012) showed no signs of anaemia or iron deficiency, liver function was normal and FOBs x 2 were negative. [Dr B] states usual practice at her surgery is that normal results are not routinely notified (except cervical smear results) and most patients are aware of this. Consequently [Mrs A's] results were not notified to her and no formal follow-up undertaken.

Comment: [Mrs A] was now complaining of persistent bowel symptoms, concerning to her, for over four years. Admittedly, there had been a two and a half year hiatus in which the symptoms had not been brought to [Dr B's] attention. The latest symptoms included ongoing mucous loss per rectum (which can be a feature of both IBS and CRC) and some recent atypical pain (tailbone area) associated with passage of possible altered blood. Abdominal examination was normal and rectal examination (which I will assume to have been done) was evidently normal (as it was five months later when done by [Dr C]). Weight was 3kg less than the previous recording in 2009,

but the same as recordings in 2008. Blood tests and FOBs were not suspicious for significant occult blood loss. I am mildly to moderately critical of some features of [Dr B's] management of [Mrs A] at this point: I think there was insufficient weight given to reconsidering those potential 'red flags' associated with the diagnosis of IBS that were discussed in section 5 – in particular the episode of possible altered blood loss and the atypical 'tailbone' (?rectal) pain reported by [Mrs A] on this occasion; I have some doubt that it was clinically reasonable to persist with a diagnosis of IBS without seeking to exclude organic disease (via referral to a gastroenterologist or endoscopist) given the factors discussed previously, even though a diagnosis of CRC appeared somewhat less likely given [Mrs A's] apparent low risk, the chronicity of the condition and absence of CRC 'red flags' such as unexplained weight loss, anaemia, confirmed rectal blood loss or abdominal mass; given [Mrs A's] concern at her symptoms, I think it would have been a reasonable expectation that she was notified of her normal results for the sake of reassurance and as an opportunity to discuss follow-up; if referral for endoscopy was not to be considered at the March 2012 consultation, I think there should have been an arrangement in place for formal review within three months (or sooner if there were further episodes of rectal pain or possible bleeding) to further discuss management options (both investigation and treatment) if the symptoms were persisting. However, I suspect the absence of 'red flags' ([Dr B] did not obtain a history of fresh rectal blood loss on this occasion, and had not since 2008) would have meant [Mrs A's] referral (if in the public system) would have had relatively low priority and she may well have not been seen any sooner than her eventual specialist consultation. Referral to a specialist in private at this point is likely to have led to an earlier diagnosis of her rectal cancer by five months which may or may not have had prognostic implications. Referral in 2008 is likely to have had significant treatment and prognostic implications for [Mrs A], assuming an early rectal tumour was present and responsible for her symptoms at this time.

9. [Dr B] did not see [Mrs A] again. On 21 August 2012 [Mrs A] attended [Dr C] to address two problems: a recent shoulder injury and the bowel symptoms. Notes relevant to the bowel include *bowels erratic for a couple of years, although better lately since taking cherry syrup … but episodes of rectal bleeding, fresh blood after BM's, occ faecal urgency, sometimes mucous with motions, painful 'tail bone' at times …OE abdo N, anus & pr NAD.* [Dr C] referred [Mrs A] for specialist review and an endoscopy on 4 September 2012 a rectal tumour was found with histology confirming adenocarcinoma. Unfortunately subsequent imaging revealed local spread and liver metastases ([Mrs A] is 54 years old at the time of diagnosis).

10. In conclusion, I feel there are aspects of [Dr B's] management of [Mrs A] that departed from expected standards up to a moderate degree, but possibly exceeding this depending on her response to the query noted in section 5. I will not make any specific recommendations until this additional information is obtained."

Further advice provided by Dr Maplesden

"I have reviewed the response from [Dr B] to [my earlier advice].

1. [Dr B] clarifies the reasoning behind her assumption at the consultation of 6 May 2008 that [Mrs A's] symptom of rectal bleeding was likely to be associated with

haemorrhoids. While there was no documented past history of haemorrhoids available to [Dr B], [Mrs A] apparently conveyed a history of having had haemorrhoids since childbirth, and that these haemorrhoids bled intermittently (outlet-type bleeding described) and the bleeding currently experienced was consistent with that previously attributed by [Mrs A] to her haemorrhoids. [Mrs A's] primary concern at this consultation was development of explosive diarrhoea rather than the episodic bleeding. As discussed previously, [Mrs A] was in a low risk group for having a diagnosis of colorectal cancer (CRC). There were additional mitigating factors also discussed in my original advice. I acknowledge that a rectal examination at this point may well not have altered [Mrs A's] subsequent management depending on whether there was evidence of haemorrhoids (reassuring) or no evidence (alternative source of rectal bleeding to be considered). I would not expect a diagnosis of CRC to have been made at this point (and it is not certain the cause of symptoms at this stage was the rectal cancer). Taking into account [Mrs A's] assurances to [Dr B] that the rectal bleeding was not a 'new' symptom but was pre-existing, unchanged in character, and had been previously attributed to haemorrhoids, I think the failure to undertake a rectal examination on this occasion was a moderate rather than moderate to severe departure from expected practice, particularly as [Dr B] implies there was an intention (not previously stated) to perform a rectal examination, or at least anal inspection, at the time of [Mrs A's] upcoming cervical smear. I cannot explain why [Mrs A] did not re-present for many months when her symptoms failed to settle (assuming they did not settle in the interim), and when she did present again complaining of bowel symptoms (August 2009) the clinical picture appeared somewhat different (no blood or mucous PR). These factors need to be considered when determining the standard of [Dr B's] management of [Mrs A].

2. [Dr B] expresses a concern that I referred to guidelines that were released a year after her 2008 consultation with [Mrs A]. The presence of rectal bleeding associated with a persisting change in bowel pattern has long been regarded as a 'red flag' presentation raising suspicion of CRC, that suspicion increasing with increased patient age. The recommendation to perform a rectal examination in a patient presenting with these symptoms has also been part of accepted practice for many years with the aphorism 'if you don't put your finger in it, you put your foot in it' being instilled at medical school years before the guidelines referred to were published. If anything, the guidelines 'tightened up' recommended criteria for referral for suspected CRC by using accumulated evidence (eg that a change in bowel pattern to looser bowel motions is more significant than development of constipation) on which to base the recommendations.

3. My comment regarding notification of normal results to an anxious patient revolved more around using this as an opportunity for follow-up rather than recommending all patients are notified of normal results. I agree with [Dr B] that it is impractical to formally notify patients of normal results, although all patients should be made aware they are able to contact the medical centre for results if they so wish. My primary concern regarding the consultation of 13 March 2012 was there did not appear to be a specific management plan for [Mrs A's] very persistent bowel symptoms, symptoms which were causing her some concern and had apparently not resolved with previous treatment given. While blood tests and faecal occult blood

testing (acknowledging limitations of the latter test) did not give rise to particular concern, [Dr B] was faced with a patient who had a four year history of loose bowel motions causing her distress (although evidently not sufficient to consult frequently on the matter), with recent development of some atypical pelvic pain and possible episode of melaena. No active treatment was provided at the consultation in question with emphasis quite appropriately being on further investigation at that time. However, when investigations failed to clarify a diagnosis (or did not raise suspicion of a sinister diagnosis), there was no follow-up to actually manage the symptoms eg if symptomatic/poorly controlled irritable bowel syndrome was still suspected, a trial of a soluble fibre preparation or advice on FODMAP diet might have been considered.

4. [Dr B] has outlined the steps she has taken, including changes in her practice, since receiving the complaint from [Mrs A]. I think these actions are appropriate to the situation and should reduce the risk of a similar incident occurring in the future. However, there will always be patients with CRC whose presentations are sufficiently atypical for CRC, or more typical for alternative non-sinister and common diagnoses, that delays in diagnosis of the underlying pathology become inevitable. There were some atypical features in [Mrs A's] presentation as discussed in my original advice, particularly the absence of anaemia or weight loss even when her cancer was well advanced, and the overall protracted course of the illness prior to the diagnosis being made. Taking all factors discussed into account, I feel that aspects of [Dr B's] management of [Mrs A] met, but did not exceed, a moderate level of departure from expected practice."

Additional advice provided by Dr Maplesden

"The issue here is really whether or not there were significant clinical concerns at the visit of 3 August 2009 to warrant referral for colonoscopy whether in private or public. Basing my opinion purely on the history presented (and discussed in some detail in section 8 of my original advice) I think there was low suspicion for a malignant bowel lesion as the cause of the patient's diarrhoea but there were some features that were not typical for the provisional diagnosis of irritable bowel syndrome. Faecal occult bloods were negative and we know, in hindsight, that even had an abdominal and rectal examination been performed at this point they would not have shown any abnormality. Likewise, a blood test would not have shown any anaemia. So there were few indications for referral for colonoscopy (which is not an innocuous procedure and required clinical indications rather than just patient request) but there were some indications for referral for gastroenterology review (which may or may not have resulted in colonoscopy), or at least a trial of specific treatment to address the patient's symptoms (usually a bulking agent and/or FODMAP diet) with formal follow-up arranged to assess response. I would expect the issue of medical insurance to be raised when referring a patient for a specialist opinion in other than an urgent situation, but the issue is unlikely to be raised unless the GP feels referral is warranted in the first place. If the patient had specifically requested further specialist review because of the ongoing distress her symptoms were causing her, I would have expected [Dr B] to consider a gastroenterology referral. This would very likely have had low priority in the public system given the relative absence of 'alarm' symptoms at this point and a picture suggestive of some form of functional bowel disorder. This issue might then have been discussed with the patient and the question of medical

insurance raised, with a private referral made if agreed. Ideally, the option of private referral should always be offered if it is available and appropriate - some patients without medical insurance are prepared to pay for the convenience and timeliness of private care.

So, in summary, I would not regard the failure to refer the patient for colonoscopy on 3 August 2009 to be a departure from expected standards, even if the examination had been specifically requested and the patient stated she was willing to pay for it or had insurance. However, the apparent failure to have a structured management and follow-up plan in place for the patient's persisting symptoms (a plan that might have included gastroenterologist referral, trial of specific treatment, or further investigation if initial tests (FOBs) were inconclusive) was a mild departure from expected standards under the circumstances noting there is a not unreasonable assumption that the patient will return for review if there are persistent symptoms. Unfortunately, on this occasion the patient perceived the GP to be dismissive of her symptoms (the GP stating there was never such an intention) and was therefore not inclined to re-present."