General Practitioner, Dr B
Medical Centre

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC02065)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by two general practitioners at a medical centre in 2020, and the delayed diagnosis of metastatic oesophageal cancer.

2. The woman attended two consultations at the medical centre with symptoms of fatigue, weight loss, and eating difficulties. She presented to the Emergency Department at the public hospital and was diagnosed with metastatic oesophageal cancer. Sadly, the woman passed away a few weeks later.

Findings

3. The Deputy Commissioner found Dr B in breach of Right 4(1) of the Code for failing to examine the woman's abdomen during a consultation. The Deputy Commissioner criticised the standard of Dr C's documentation and the medical centre's referral management processes, and the absence of any policies for the management of locum doctors.

Recommendations

4. The Deputy Commissioner recommended that Dr B provide the family with an apology for the failings identified in this report and review the Community HealthPathways guidance on "Dysphagia and Dyspepsia and Heartburn/ GORD".

5. The Deputy Commissioner recommended that the current owner of the medical centre consider the implementation of a new management process for filing of documentation and consider making changes to the management of referrals to ensure accuracy and consistency in referrals. The Deputy Commissioner also recommended that the medical centre consider implementing a new system/policy for the appropriate management of locums, to ensure continuity of care.

Complaint and investigation

6. This report is the opinion of Carolyn Cooper, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

7. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to his late wife, Mrs A, by Dr B at a medical centre[1]. The following issues were identified for investigation:

- *Whether Dr B provided Mrs A with an appropriate standard of care between 31 Month1[2] and 27 Month2 (inclusive).*

[1] The medical centre now has a new owner.
[2] Relevant dates are referred to as Months 1-2 to protect privacy.

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- *Whether the medical centre provided Mrs A with an appropriate standard of care between 10 Month1 and 27 Month2 (inclusive).*

8. The parties directly involved in the investigation were:

Mr A	Complainant
Dr B	General practitioner (GP)
Medical centre	

9. Further information was received from GP Dr C.

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

Information gathered during investigation

Background

11. This report concerns the delayed diagnosis of Mrs A's metastatic oesophageal cancer.[3]

12. Mrs A (aged in her sixties at the time of events) had a history of high blood pressure, systemic lupus erythematosus,[4] and heavy drinking. In Month1, Mrs A attended two consultations at a medical centre with symptoms of fatigue, weight loss, and eating difficulties. On 5 Month2, Mrs A presented to the Emergency Department (ED) at the public hospital and was diagnosed with metastatic oesophageal cancer. Sadly, Mrs A passed away a few weeks later. I offer my sincere condolences to Mrs A's family for their loss.

10 Month1 — consultation with Dr C

13. Dr C[5] told HDC that at the time she was working in a part-time capacity at the medical centre as a locum, providing between one and three short afternoon sessions per week, and this was due to finish in mid-Month2. Dr C noted that this work occurred on site, and there was no way for her to access patient notes remotely, and she also had no after-hours access to the clinic to access notes and check results.

14. Mrs A attended a consultation with Dr C on 10 Month1. Mrs A presented with several symptoms, including fatigue, loss of appetite, 7kg weight loss over the previous two months, feeling cold, tingling limbs, reddened palms, and a history of poorly fitting dentures interfering with her chewing.

15. Dr C requested blood tests for a general initial investigation.[6] She said that she made a request to the public hospital for an ultrasound scan of Mrs A's liver (noted to be "firm" on

[3] Cancer of the tube that runs from the throat to the stomach (the oesophagus).
[4] An inflammatory disease caused when the immune system attacks its own tissues.
[5] Dr C is a member and fellow of the Royal New Zealand College of General Practitioners.
[6] Blood tests included a complete blood count, B12, folate, TSH, liver and renal function tests.

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examination). The request form stated the clinical indication as: "[History] **very**[7] heavy alcohol intake. [Right upper quadrant] liver feels hard/shrunken? ? cirrhotic [scarred and damaged]." Dr C also submitted a request for a mammogram, as it was overdue. The clinical notes record the request for a bilateral mammogram, but there is no mention of the liver ultrasound. In her response to the provisional opinion, Dr C told HDC that she generated a paper copy of the liver ultrasound request and handed this to practice staff to be sent to Radiology at the public hospital.

16. Dr C told HDC that Mrs A was thin but did not show any "red flags" of a rapidly progressive condition (such as dysphagia (difficulty swallowing)), and for this reason Dr C did not indicate any need for urgency on the request form. Dr C told HDC that dysphagia is a very significant symptom, and she is confident that had this been mentioned, particularly given the history of weight loss, she is certain that she would have recorded this and acted on this specific information with both a referral and a telephone call.

17. Dr C told HDC that the consultation room at the medical centre that was made available to her on 10 Month1 had computer and printing issues. Because of the computer issues, Dr C had to re-write from memory some of the patient notes. Dr C could not recall whether Mrs A's notes were among these, although she noted that on reviewing the relative brevity of the notes from this consultation (compared to her normal standard for documentation), it is likely that she did have to re-write these notes.

18. The Medical Council of New Zealand statement on "Managing Patient Records"[8] notes:

> "Records must be completed at the time of the events you are recording, or as soon as possible afterwards … If you need to correct or add notes to your patient's records sometime after an event, these must be clearly identified as corrections or additions. The notes must be initialled or signed, and accurately dated as to when the changes were made."[9]

19. Dr C told HDC that she believes the lack of documented differential diagnosis was likely due to her having re-written the notes later that day. Dr C said that the management plan was for blood tests and an ultrasound scan, as is evidenced by the requests she made, and she believes that a colleague reading the file would have been clear on the plan. Dr C accepted that the "safety-netting" advice was not recorded, but again she believes that this was because she had to re-write the notes.

20. Dr C told HDC that the completed request for Mrs A's overdue mammogram indicates that the consultation did cover more than what was indicated by the brief notes, and the finding that this was due would have been evident only by her reviewing Mrs A's screening history.

[7] Underlined on the request form.
[8] Statement updated in October 2019.
[9] At 6.

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17–28 Month1

21. On 17 Month1, Dr C followed up her ultrasound request to ensure that Mrs A had an appointment booked. As she was uncertain whether the original request from 10 Month1 had been received by Radiology, she refaxed the request to ensure receipt.

22. On 17 Month1, Dr C also had a telephone conversation with Mrs A to discuss her blood test results. Dr C advised Mrs A that the results were normal apart from indicating that her thyroxine[10] dose was possibly low. The details of the call were not noted in the clinical documentation.

23. On 19 Month1, a letter was sent to Dr C by the Radiology Department at the public hospital regarding the ultrasound request. The letter was sent to another practice at which Dr C worked.

24. The letter documented that Mrs A had been prioritised as "category C", which indicates that the estimated wait time for an ultrasound is 30–38 weeks. Further to this, the letter stated that the referring clinician should review the prioritisation against the clinical picture, and that should the clinician consider the prioritisation not to be clinically appropriate, they should forward any additional relevant information to Radiology.

25. Mr A told HDC that he considers that Dr C did not review the prioritisation for the scan against Mrs A's clinical picture. Dr C told HDC that because the letter was sent to the wrong practice, the electronic version of the letter would also have been sent to the electronic record system of the wrong practice. She noted that the paper version of the letter had not been signed as having been seen by her. Dr C said that it had been her normal practice for 30 years to sign paper reports when viewing them, and to detail any action needed and taken as appropriate for the information contained. The signed report is then filed in the patient notes after being actioned.

26. Dr C told HDC that the electronic version of the letter would have been sent to the electronic record system of the other practice and would have been stored as an unmatched patient.

27. Dr C said that she has no memory of having seen the letter from the public hospital. She noted that if she had been aware of the delay, she would have telephoned the public hospital to request an appointment earlier than the indicated waiting time.

28. The letter was eventually received by the medical centre as a hard copy on 23 Month1, as documented in the clinical notes as "scanned document — from radiology", and as filed by "X".

29. The medical centre told HDC that "X" refers to the workstation that was being worked on at the time. The medical centre said that the audit logs show that the receptionist scanned the letter into the patient management system.

[10] Used to treat thyroid hormone deficiency.

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30. The medical centre told HDC that all hard copy letters are scanned into the patient management system by the reception staff on the day they are received. The letters are then placed in the physical box of the relevant doctor for the doctor's review (in this case Dr C). The hard copy letters and updates to the patient's electronic file are then processed by Dr E, and following this the letter is returned to reception and shredded. According to the audit, this was done on 28 Month1 by Dr E.

31 Month1 — consultation with Dr B

31. On 31 Month1, Mrs A attended a consultation with Dr B[11] at the medical centre, along with her husband. Dr B told HDC that this was a long consultation and, as Mrs A looked unwell and weak, most of the communication was with Mr A.

32. Mr A told HDC that the family was very concerned about Mrs A at this time. Mrs A had continued to lose weight and was eating only a few mouthfuls a day. She could not swallow solids and could barely manage liquids (dysphagia). He said that Dr B mentioned GORD (gastro-oesophageal reflux disease) as a possible diagnosis, but Mrs A did not have indigestion symptoms, and the main issue was her inability to eat. Mr A felt that Dr B did not listen to him when he raised this.

33. Mr A told HDC that Dr B failed to examine Mrs A's abdomen, despite her ongoing symptoms of weight loss, loose black stools, and difficulty swallowing food. Mr A stated that Dr B also did not review the prioritisation for the ultrasound scan Dr C had ordered.

34. Dr B told HDC that he was concerned about Mrs A's ongoing loss of weight and difficulty eating. She had also reported passing black motions (stools) at times. Although he could not make a firm diagnosis, he was concerned that she had a serious condition of her upper gastrointestinal tract. He was aware of her history of high alcohol intake, and acknowledged that that could cause upper gastrointestinal problems, including inflammation and bleeding.

35. Dr B told HDC that he prescribed omeprazole[12] in the hope that the resultant reduction in stomach acid production would prevent further bleeding and help swallowing if that was being affected by oesophageal reflux. He advised Mrs A to weigh herself regularly to monitor any weight loss, and prescribed a low dose of thyroxine in view of her blood test results in case her reduction in thyroid activity was contributing to her lack of energy. He documented the plan in Mrs A's notes as follows:

> "Script as below as per discussion, review in 4–6 weeks and repeat bloods as per lab form prior, weekly weigh herself at home before or after shower in her diary, review earlier if worse, if ongoing difficulty swallow with above treatment, refer for gastro to rule out ca[ncer]."

36. Mr A noted in his complaint that Dr B had documented, "if ongoing difficulty swallow with above treatment, refer to gastro to rule out ca", but that Dr B did not discuss this with him.

[11] Dr B is no longer working out of the medical centre.
[10] A medication used to treat indigestion.

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37. Dr B told HDC that he discussed the results of the blood tests with Mrs A. They showed a very slight underactivity of the thyroid gland but otherwise were normal apart from her iron and ferritin levels, which were reported as being likely indicative of inflammation. Mrs A indicated that she still had trouble swallowing and had low energy. Dr B told HDC that given that Mrs A had had a recent thorough examination by Dr C, and as Mrs A was so unwell, he did not feel that any other physical examination at that stage would affect his suggested management, which was referral to hospital for further investigation and additional blood tests.

38. Dr B documented a plan for Mrs A, which was to prescribe levothyroxine[13] and omeprazole, review her again in four to six weeks' time, and to repeat the blood tests. The plan also included taking Mrs A's weight weekly, reviewing her earlier if symptoms worsened, and referring her to Gastroenterology if she had ongoing difficulty swallowing, to rule out cancer. Dr B documented that Mrs A agreed with this plan.

39. Dr B stated that although it is not documented in the clinical notes, he recalls advising Mrs A that she should be admitted to hospital that day. He told HDC that this offer was declined as it was a public holiday. Dr B said that in regard to not documenting the recommendation that Mrs A attend the Emergency Department immediately on 31 Month1, it was his impression that she would attend shortly thereafter, and this was in the forefront of his mind when making the management plan. Mr A does not recall Dr B advising this.

Subsequent events

40. Mr A told HDC that five days after Mrs A was seen by Dr B, her condition worsened and she was no longer able to swallow liquids. Mr A took her to the Emergency Department at the public hospital on 5 Month2.

41. Mrs A was admitted under Gastroenterology and diagnosed with metastatic oesophageal cancer with liver and lung metastasis. She was referred to palliative care services for symptom control and support following discharge and supplied with an advanced care plan. Mrs A passed away on 27 Month2.

Further information

Dr C

42. Dr C told HDC that she is in no way judgmental of people with hazardous substance abuse and addictions, and she treats all patients in a respectful manner and works in agreement with them to manage their health problems and minimise harm.

Dr B

43. Dr B told HDC that he would like to express his sincere sympathy to Mr A and his family for their loss.

[13] Used to treat thyroid hormone deficiency.

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Responses to provisional opinion

Mr A

44. Mr A was given the opportunity to respond to the "information gathered" section of the provisional opinion. He stated that he felt that Dr C did appropriate preliminary investigations into his wife's care, and said that his wife had not been to the doctor for a long time and attended only after he insisted that she go. Mr A noted the effect this delay had on her diagnosis and rapid decline and stated that the clinicians involved did not have a chance to investigate further as, sadly, she deteriorated so quickly.

Dr C

45. Dr C was given the opportunity to respond to the provisional opinion. Her response has been incorporated into this report, where relevant.

Dr B

46. Dr B was given the opportunity to respond to the provisional opinion. Dr B made no comments on the provisional opinion and stated that he had no objection to the proposed recommendations.

Medical centre

47. The medical centre was given the opportunity to respond to the provisional opinion. One of its former directors told HDC that he does not intend to make any further comment.

48. The current owner of the GP practice stated that it fully accepts the recommendations and follow-up actions outlined in the provisional opinion. It acknowledged its responsibility to address the areas that require improvement and advised that implementation of the recommendations will be treated as a priority, and it is confident that this will have a positive impact on the quality of care provided to patients.

Opinion: Introduction

49. Mrs A was seen by two providers at the medical centre in Month1. She presented with worsening symptoms in a short period of time, and was diagnosed with oesophageal cancer shortly afterwards, during a hospital admission.

50. Issues that may have contributed to a delayed diagnosis were the lack of a physical examination during the 31 Month1 consultation and the appropriateness of Dr B's management decisions, and poor management by locums at the medical centre.

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Opinion: Dr C — adverse comment

51. Dr C saw Mrs A at the medical centre on 10 Month1. At the time, Dr C was working as a locum in a part-time capacity at the medical centre.

Physical assessment

52. Dr C requested blood tests for a general initial investigation. She told HDC that she made a request to the public hospital for an ultrasound scan of Mrs A's liver (noted to be "firm" on examination). The request form sent on 10 Month1 mentions only a bilateral mammography, and not the ultrasound request as per Dr C's statement. However, it is clear that a request was sent, as an ultrasound was scheduled.

53. Dr C told HDC that Mrs A was thin but did not show any "red flags" (such as rapidly progressing dysphagia), and for this reason, no need for urgency was noted on the request form. My in-house GP advisor, Dr David Maplesden, also considered that the overall clinical picture (poor nutrition with weight loss, possible mild cerebellar symptoms and peripheral neuropathy (nerve damage), palmar erythema (reddening of the palm of the hand), and a firm liver) would be consistent with prolonged alcohol consumption, and that this was a very reasonable working diagnosis. He noted that in addition, the history of poorly fitting dentures interfering with chewing was another factor presented by the patient as related to her weight loss, with the two factors (dentures and alcohol use disorder) meaning that the weight loss was not necessarily "unexplained". Dr Maplesden advised that the physical assessment was appropriate.

54. I accept this advice and consider that the physical assessment of Mrs A by Dr C was appropriate and adequate in the circumstances and clinical situation.

Documentation

55. Dr C told HDC that the room that was made available to her on 10 Month1 had computer and printing issues. Because of the computer issues, Dr C had to re-write from memory some of the patient notes. She could not recall whether Mrs A's notes were among these but noted that on reviewing the relative brevity of the notes from this consultation (compared to her normal standard of documentation), it is likely that she did have to re-write these notes that day.

56. Mrs A's clinical notes document that she presented with a number of symptoms, including fatigue, loss of appetite, feeling cold, and tingling limbs.

57. Dr Maplesden advised that the link between past alcohol use and the presenting symptoms was explored in some detail by Dr C. He noted that there was no reference to a presentation of progressive dysphasia or dyspepsia[14] as symptoms, although the relevant finding of a normal bowel pattern was documented. Dr Maplesden considers that the content of the recorded history would be met with general approval by his peers. He noted that if Mrs A did report a history of progressive dysphagia or other upper gastro-

[14] Indigestion.

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intestinal symptoms, this should have been documented, and he would be at least moderately critical if these symptoms were present and not documented.

58. The clinical notes typed up following the consultation on 10 Month1 do not mention dysphagia, and Dr C told HDC that she has no recollection of it having been mentioned, and that had it been, she is sure she would have noted it as a significant red flag. Dr C reiterated this point in response to the provisional opinion. I find it more likely than not that there was no discussion of dysphagia, and therefore I accept Dr Maplesden's advice that there was no issue with that aspect of Dr C's documentation.

59. However, Dr Maplesden was mildly to moderately critical of the standard of clinical documentation in relation to the absence of a diagnosis or diagnostic formulation. He advised that no clear management plan or follow-up was documented, nor any "safety-netting" advice (symptoms to watch for, and when to seek further medical assistance). He noted that this criticism extended to documentation of the content of the telephone call on 17 Month1.

60. Dr C told HDC that she believes that the lack of a documented differential diagnosis was likely due to her having re-written the notes later that day. She noted that the management plan was for blood tests and an ultrasound scan, as evidenced by the requests she made, and she believes that a colleague reading the file would have been clear on the plan. However, the referral request on 10 Month1 notes only a mammography, and the first mention of an ultrasound request is on 17 Month1.

61. Dr C accepts that no safety-netting advice was recorded, but again she believes this was due to the need to re-write the notes. Dr C considers that the limitations of her documentation did not have any negative impact on the care she provided to Mrs A. Dr C stated that Mrs A was clearly aware of the plan as she went to have her blood tests done. However, I do not accept that Mrs A's action in undertaking blood tests indicates that she was clearly aware of the management plan or had been given safety-netting advice.

62. The Medical Council of New Zealand (MCNZ) guidance on "Managing Patient Records" states:

> "Records must be completed at the time of the events you are recording, or as soon as possible afterwards … If you need to correct or add notes to your patient's records sometime after an event, these must be clearly identified as corrections or additions. The notes must be initialled or signed, and accurately dated as to when the changes were made."

63. While I acknowledge that Dr C may have faced technical issues on 10 Month1, which required her to re-write Mrs A's notes at the end of the day from memory, there is no note to indicate that the clinical documentation was in fact re-written and added later. I remind Dr C of the importance of ensuring that clinical documentation is made contemporaneously, is accurate, and records whether the information has been added or re-written at a later time.

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Ultrasound scan follow-up

64. Dr C said that following the appointment on 10 Month1, she wrote a referral letter to the public hospital for an ultrasound to investigate Mrs A's liver. She stated that she handed this to practice staff to be sent, as she did not have access to the practice fax machine. Although this is not noted in the clinical documentation, Dr C said that she followed up the request on 17 Month1, and re-faxed the request to ensure that it was received.

65. On 19 Month1, a letter was sent from the Radiology Department at the public hospital indicating that there would be a significant wait time (30–38 weeks) for the ultrasound. Unfortunately, the paper letter was addressed to Dr C at another practice at which Dr C worked. Dr C told HDC that the electronic version of the letter sent to this practice would have been stored as an unmatched patient.

66. Dr C stated that the paper version of the letter has not been signed as having been seen by her. She noted that her normal practice for 30 years has been to sign paper reports when she sees them, and to detail any action needed or taken as appropriate for the information contained. The signed report is then filed in the patient notes after being actioned.

67. Dr Maplesden advised that it was desirable to track Mrs A's ultrasound referral to ensure that it was completed within a reasonable timeframe. He said that although it is unclear whether this occurred, Dr C was conscientious in checking the referral status on 17 Month1 and re-faxing the referral.

68. It appears that eventually the letter was received by the medical centre as a hard copy, with notes referring to it having been filed by "X" on 23 Month1. I am unable to identify the person who viewed the letter when it was received at the practice. Dr C has no recollection of ever having viewed the letter and stated that her standard practice was to sign and annotate every hard copy document reviewed prior to scanning and filing it. She said that had she seen the letter, she would have contacted the public hospital to increase the prioritisation of Mrs A's scan. There is no signature or annotation on the letter.

69. Dr C is firm in her recollection that she was never given the opportunity to review the electronic or hard copy of the letter from the public hospital that noted a likely delay in scheduling Mrs A's ultrasound.

70. The medical centre disagreed with Dr C's recollection of events, and provided an audit that shows that the letter was received on 23 Month1. The medical centre said that initially the hard copy of the letter was placed in Dr C's "box", and then returned to reception to be processed and filed, which occurred on 28 Month1. The medical centre considers that Dr C did view the letter.

71. While the audit does show that the letter was received and processed by the medical centre, it does not provide any certainty as to what happened to the letter between 23 and 28 Month1, ie, whether or not Dr C viewed the letter. Therefore, I am unable to make a finding on this issue. However, I acknowledge Dr C's actions in following up and re-faxing the request. In response to the provisional opinion, Dr C noted that she is certain that had

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she seen the letter, she would have actioned and signed the document pursuant to her usual practice of doing so.

Opinion: Dr B — breach

Introduction

72. Mrs A and her husband attended a consultation with Dr B on 31 Month1. Mrs A presented with similar but worsening symptoms to those she had on 10 Month1 when she was seen by Dr C. Despite this, Dr B did not re-examine Mrs A or examine her abdomen.

Inadequate examination

73. Dr B told HDC that as Mrs A had had a thorough examination by Dr C on 10 Month1, and given that Mrs A was so unwell, he did not feel that any other physical examination was necessary or would affect his suggested management.

74. Dr Maplesden noted that the clinical documentation indicated that Mrs A appeared very unwell, with deterioration in her symptoms since her previous review on 10 Month1. New symptoms of dysphagia and possible intermittent melaena[15] were recorded, although Mrs A had no current melaena. Dr Maplesden advised that in this clinical scenario, he would expect recording of vital signs to ensure haemodynamic stability (stable blood flow) in case of a concealed gastrointestinal (GI) bleed, and review of previous abdominal findings. He considers that the examination undertaken by Dr C on 10 Month1 did not remove the need for Dr B to re-examine Mrs A, particularly in light of her newly recorded significant symptoms.

75. Dr Maplesden advised that the failure by Dr B to examine Mrs A on this occasion would be met with moderate disapproval by his peers, whether or not hospital admission was considered, and certainly once admission was declined by Mrs A.

Management plan

76. Dr B documented a plan for Mrs A that consisted of prescribing levothyroxine and omeprazole, and reviewing her again in four to six weeks' time and repeating blood tests. The plan included taking Mrs A's weight weekly, reviewing her earlier if symptoms worsened, and referring her to Gastroenterology if she continued to have difficulty swallowing, to rule out cancer. Dr B documented that Mrs A agreed with this plan.

77. Dr Maplesden advised that acute specialist referral should have been considered at this appointment, given the possible history of recent intermittent melaena. Mrs A was at increased risk of oesophageal varices[16] and other significant upper gastrointestinal pathology because of her alcohol use disorder. Dr Maplesden considers that if Mrs A had

[15] Dark-coloured stool containing blood.
[16] Abnormal, enlarged veins in the oesophagus (the tube that connects the throat and stomach).

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showed signs of haemodynamic instability, acute admission to hospital (with Mrs A's consent) should have occurred. Dr Maplesden advised that if her condition was stable with no current evidence of gastrointestinal bleeding, and she was reluctant to attend ED, immediate blood testing was indicated to assess the degree of blood loss (if any), and to enable further discussion of the possible need for acute admission.

78. Dr Maplesden said that the combination of progressive dysphagia, weight loss, and possible melaena were indications for urgent gastroenterology assessment (if acute admission was declined), ideally with a high suspicion of cancer noted. While it was reasonable to commence a proton pump inhibitor (PPI)[17] in the interim, this trial should not have delayed the gastroenterology referral, and it was inappropriate to wait four to six weeks before checking blood test results or deciding whether or not to make the referral.

79. Dr Maplesden advised that given the clinical scenario described in the notes, Dr B's documented management decisions would be met with moderate disapproval by his peers.

80. Dr B told HDC that he recalls advising Mrs A that she should be admitted to hospital that day. He said that this offer was declined as it was a public holiday. Mr A does not recall Dr B advising this, and such a recommendation is not recorded in Mrs A's clinical notes. Based on the evidence available to me, I find it more likely than not that Dr B did not advise Mrs A to go to the hospital that day.

81. Dr Maplesden advised that given Mrs A's unwellness on 31 Month1, and her risk factors for serious underlying pathology, including active upper GI bleeding, the failure by Dr B to explore the option of acute hospital admission would be met with at least moderate disapproval by his peers. I accept this advice.

Conclusion

82. During the consultation on 31 Month1, several elements of the care provided by Dr B fell below appropriate standards, namely, Dr B's decision not to examine Mrs A's abdomen, and the appropriateness of his management decisions. Therefore, I find that Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[18]

83. I note Dr Maplesden's comment that even if a referral for gastroenterology assessment had been made on 10 or 31 Month1, this is unlikely to have altered the rapid course of Mrs A's illness (even with a high suspicion of cancer, a wait of up to two weeks for specialist review is expected). However, it affected the amount of time Mrs A and her family had to adjust to her devastating diagnosis.

[17] Medication used to reduce stomach acid production.
[18] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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Opinion: Medical centre

84. The medical centre was Mrs A's regular medical centre. She was treated by two different general practitioners at the medical centre in Month1, shortly before her diagnosis of oesophageal cancer.

Locum management — adverse comment

85. At the time of the 10 Month1 consultation, Dr C was working as a locum on a short-term basis, until mid-Month2. At the core of the issues surrounding Mrs A's care is the appropriate management of locums by medical centres to ensure continuity of care.

86. Dr C noted that during the 10 Month1 consultation she had technical issues, and that she had limited access to clinical records, as she could access them only when she was present on site, and not after hours.

87. Dr Maplesden advised that as Dr C's locum attachment was due to end in mid-Month2, the practice should have had in place a process for ensuring the appropriate management of outstanding results and tasks of short-term locums once their attachment had finished.

88. I accept this advice. HDC requested copies of the medical centre's policies and procedures to ensure the appropriate management of outstanding results and tasks of short-term locums once their attachment has been completed. The medical centre has yet to respond to the request or to provide any evidence of policies it holds. Accordingly, I find it more likely than not that the medical centre did not have any policies or processes in relation to this issue. Given that the GP practice changed ownership, I consider it appropriate for the current owner to reflect on the issue of locum management and the policies and processes that are needed to resolve the issues.

Referral management — other comment

89. Regarding the issue of the letter that was sent to Dr C by the Radiology Department at the public hospital, the medical centre told HDC that the clinic's audit logs show that the receptionist scanned the letter into the patient management system, as per the usual practice. The medical centre said that the letter would then have been placed in the physical box of the appropriate doctor, in this case Dr C. After being viewed by the appropriate doctor, the hard copy would then be returned to reception staff and given to Dr E. The medical centre noted that on 28 Month1, the scanned letter was returned to the reception staff and placed with Dr E to be filed electronically.

90. The medical centre told HDC that Dr C's recollection does not match its audit logs.

91. The audit log shows that the letter was scanned by the receptionist on 23 Month1 and filed by Dr E on 28 Month1. However, it gives no certainty as to what happened to the letter between those dates. I acknowledge this uncertainty.

92. Dr Maplesden advised that from an electronic audit perspective, it would be more effective if the provider who is taking responsibility for the correspondence is also

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responsible for filing the electronic copy. He said that in his experience, this approach is much more common than the process described at the medical centre.

93. I accept this advice. Although I am unable to make a finding regarding the medical centre's management of the referral letter, I emphasise the importance of a coherent and consistent practice for referral management and will make a recommendation to that effect.

Changes made

Dr B

94. Dr B told HDC that he agrees that his recommendation for hospital admission and Mrs A's indication that she would attend after New Year should have been recorded. He said that since 21 October 2021 he has had voluntary reviews of his clinical record-keeping, which has provided him with some excellent practical guidance, and that currently he is undertaking an educational programme by the Medical Council of New Zealand that includes this issue. Dr B told HDC that this has demonstrated a marked improvement in his record-keeping.

Dr C

95. Dr C told HDC that after this event she undertook the following:

a) She communicated with several of her experienced locum GP colleagues and began work on a document to outline potential pitfalls when working as a locum, as she had been unable to find such a tool. She plans to liaise on this with the Royal New Zealand College of General Practitioners.

b) She ensures that the practices she works for allow longer appointments.

c) She checks that contact details for patients are correct, and that on any referrals she makes she is identified as a locum GP for the practice.

d) She confirms the information she records with every patient, to make sure that she has heard correctly.

e) She discusses red flags and action to take — ensuring that the patient has a reliable means of seeking review (car/phone/driver, etc), and strongly encourages review if symptoms have not improved by an agreed time.

f) She provides the patient with a copy of the notes she has made, highlighting red flags/ management plan details as a concrete means of ensuring that the steps are addressed fully.

g) Following a remote or telephone consultation, she emails the notes to the patient.

h) She checks the clinic's system for handling results/letters and sets task reminders for herself and colleagues to follow up on any potential concerns.

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Recommendations

96. I recommend that Dr B:

a) Provide Mrs A's family with an apology, within three weeks of the date of this report.

b) Review the Community HealthPathways guidance on "Dysphagia and Dyspepsia and Heartburn/GORD" in light of this report, and provide a reflection to HDC within three months of the date of this report.

97. I recommend that the current owner of the GP practice:

a) Consider the implementation of a new management process for filing documentation into the system, as suggested by Dr Maplesden. The outcome of this consideration, and any changes made as a result, is to be sent to HDC within three months of the date of this report.

b) Consider, in light of the findings contained in this report, changes to the referral management at the medical centre to ensure accuracy and consistency in referrals. The outcome of this consideration, and any changes made as a result, is to be sent to HDC within three months of the date of this report.

c) Consider a new system/policy for the appropriate management system for locums, to ensure continuity of care. The outcome of this consideration, and any changes made as a result, is to be sent to HDC within three months of the date of this report.

Follow-up actions

98. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

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

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Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from GP Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [the medical centre] and the family of the late [Mrs A] about the care provided to [Mrs A] by [Dr B] and [Dr C] at [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

- Complaint from [the medical centre] and the family of [Mrs A]
- [Medical centre] response and clinical notes
- Response from [Dr C]
- Response from [Dr B]

2. The complaint relates to delayed diagnosis of oesophageal cancer with metastases. [Mrs A] presented to [Dr C] on 10 [Month1] with symptoms of fatigue, weight loss and eating difficulties. She had blood tests taken and referral made for liver ultrasound. The ultrasound request was graded non-urgent with a wait of up to 38 weeks and this was not queried by [Dr C]. [Mrs A] returned for review by [Dr B] on 31 [Month1] as she had deteriorated. [Dr B] did not examine [Mrs A] and provided capsules for indigestion which she was unable to swallow. [Mrs A] attended the public hospital ([the public hospital]) ED on 5 [Month2] and was admitted for further investigation. She was noted to have enlargement of her liver and left supraclavicular lymph node. She was diagnosed with metastatic oesophageal cancer and sadly passed away on 27 [Month2].

3. [Mrs A's] medical history (per clinical notes) includes: 30 pack-year smoking history, long history heavy alcohol intake, hypertension, hyperlipidaemia, some form of lupus diagnosed by a dermatologist (coded 2015). There is a record of medication prescribed on 17 December 2015: cilazapril, atorvastatin, cholecalciferol, thiamine and Multivite. Notes have been provided from beginning of 2017 and there are no consultations recorded from then until 10 [Month1] ([Dr C]). It appears at some stage between December 2015 and [Month1] [Mrs A] stopped attending the practice for what I presume were previously regular prescriptions.

4. Notes for the consultation dated 10 [Month1] ([Dr C]) read:

ALIM [unclear what this represents] asks for bloods

has been cutting down alcohol intake stopped 3 weeks ago

fatigue/no appetite/dentures don't fit well and can't eat

has now stopped drinking

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was drinking 2 stubbies + bottle wine every night years of doing this

has in past managed to stop for a time always restarted

wt has gone down 7 k in 2 months [weight recorded as 41kg]

feels the cold

bowel habit ok taking herbal preparation easy daily normal colour

fell last y hurt tailbone [spinal fusion years ago]

tingling all limbs feel 'funny' poss alcoholic neuropathy

OE very slender

liver palms and tremor

finger nose test sl off and adiochokinesis not good control sl broad based gait

appears orientated/alert and appropriate in speech, no signs Korsakoffs

cant chew meat

Not eating well not taking thiamine ever

abdo cachectic liver doesn't feel enlarged but is firm

not tender over pancreas

no jaundice

5. There is no documented differential diagnosis or management plan but a form was provided for blood tests and a radiology request form provided (listed as for mammogram in the clinical notes). A prescription was provided for multivitamins and thiamine. On examination of outbox documents, there is a referral for liver ultrasound on a community provider form (crossed out and addressed to [the public hospital]) stating: Hx very heavy alcohol intake, RUQ liver feels hard shrunken ?cirrhotic. Report status (same day/urgent/not urgent) is not circled. There is an additional annotation: please fax, and it appears the request form was faxed to [the public hospital] a week later (17 [Month1]). Blood test results were received on 11 [Month1] and showed normal blood count and differential, normal renal and liver function, normal B12 and folic acid levels, normal protein electrophoresis, borderline elevation of TSH with normal FT4 (possible subclinical hypothyroidism) abnormal iron studies: elevated ferritin but low iron stores, transferrin and transferrin saturation. [Dr C] has annotated the iron results: high EthOH likely cause elevated ferritin and the thyroid results underactive thyroid. On 17 [Month1] [Dr C] has recorded Adv re results.

6. [Dr C] states in her response that at the time of the events in question, she was working as a short-term part time locum at [the medical centre] doing one to three afternoon sessions a week. She had no remote access to the PMS. There were computer and printer issues in the consultation room she was assigned on 10 [Month1] and she had to re-write some consultations from memory that day although is not sure if [Mrs A's] consultation was one of them. [Mrs A] presented alone and her

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main presenting concern was that current symptoms she was experiencing was a result of years of heavy alcohol intake and she wanted blood tests to determine if this was the case. She had tried stopping alcohol on several occasions in the past but had always relapsed. [Dr C] states [Mrs A] presented a history of weight loss attributed by the patient to poorly fitting dentures interfering with eating. She did not describe any difficulty swallowing … she did not at this consultation describe any back pain so there was no reason to examine her spine. [Mrs A] described tingling in her limbs in relation to a tailbone injury the previous year which [Dr C] felt may be a peripheral neuropathy unrelated to the tailbone given the distribution of symptoms. Some mild cerebellar dysfunction was noted and attributed to [Mrs A's] alcohol use disorder. Abdominal examination revealed a thin abdomen (described as cachectic) consistent with [Mrs A's] apparent poor nutrition, and the liver was firm in texture but not enlarged. [Dr C] suspected [Mrs A's] history and physical findings were related to her alcohol use disorder although she did not discount the possibility of underlying cancer. Referral was made for blood tests to try and further clarify the diagnosis. Radiology referrals were made for screening mammogram and for liver ultrasound. Because of printer issues, the mammogram request was printed twice with one copy altered by hand to request liver ultrasound. [Dr C] states: As [Mrs A] was thin but did not show any 'red flags' of a rapidly progressive condition when I saw her on 10th [Month1] I did not indicate any need for urgency on the request form. On 17 [Month1] [Dr C] advised [Mrs A] of her results and checked with the [public hospital] radiology service whether her referral had been received. She was unable to confirm this and arranged for the request form to be re-faxed.

7. Comments:

(i) Based on the contemporaneous notes and provider response, it appears [Mrs A] saw [Dr C] primarily to discuss symptoms of fatigue, loss of appetite with weight loss, and tingling limbs which she felt might be related to her alcohol use disorder. This appears to have been explored in some detail by [Dr C] and there is no reference to presentation of progressive dysphagia or dyspepsia as a symptom although the relevant finding of normal bowel pattern has been documented. I believe the content of the recorded history would be met with general approval by my peers and is certainly more detailed than many notes I have examined. However, if [Mrs A] did report a history of progressive dysphagia or other upper GI symptoms, this should have been documented and I would be at least moderately critical if the symptom was presented and not documented. I note there is reference in later hospital documentation to progressive dysphagia for several weeks prior to admission on 5 [Month2] (see below) and it is possible there was inadequate differentiation between difficulty swallowing because [Mrs A] was unable to chew (ill-fitting dentures) versus difficulty swallowing because of a feeling of obstruction (dysphagia).

(ii) Leaving aside the issue of dysphagia (history evidently not obtained), the overall clinical picture of poor nutrition with weight loss, possible mild cerebellar symptoms and peripheral neuropathy, palmar erythema and firm liver would be consistent with prolonged alcohol use disorder and I believe this was a very reasonable working diagnosis. The history of poorly fitting dentures interfering with chewing was an

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additional factor presented by the patient as related to her weight loss with the two factors (dentures and alcohol use disorder) meaning the weight loss was not necessarily 'unexplained'. Physical assessment was adequate although given the association of hypertension and cardiomyopathy with alcohol use disorder, recording of pulse, blood reassure and heart auscultation would represent best practice. I could see no indication (based on the recorded history) for a detailed back examination.

(iii) With the reasonable assumption (based on the recorded history) that [Mrs A's] symptoms most likely represented physical effects of prolonged alcohol use disorder, I believe the initial investigations ordered by [Dr C] were reasonable. The liver ultrasound was being used to determine degree of alcohol-related structural change rather than because malignancy was suspected and urgent imaging was not indicated in this context although an increased priority might have been sought if liver function was severely deranged. However, I am mildly to moderately critical at the standard of clinical documentation in relation to absence of a diagnosis or diagnostic formulation, no clear management plan/follow-up documented and no 'safety-netting' advice documented. This applies also to the follow-up telephone consultation on 17 [Month1] when blood results were conveyed but it is not apparent what follow-up arrangements were in place given [Mrs A's] presumed ongoing symptoms.

(iv) The blood tests results were, for the most part, surprisingly normal. The picture of iron deficiency was most consistent with chronic inflammation rather than blood loss and the minimal elevation of TSH with normal FT4 was not likely to be contributing to [Mrs A's] symptoms. While the blood results were largely reassuring, they did not explain [Mrs A's] symptoms and might have been perceived as casting some doubt on the working diagnosis of progressive alcohol-related disease (no evidence of liver dysfunction, macrocytosis etc that might have been expected with more severe disease). However, it was probably reasonable to wait for receipt of the liver ultrasound result before reviewing [Mrs A] and reconsidering her diagnosis provided her condition was stable and the ultrasound wait was not prolonged. Had [Mrs A] complained of progressive dysphagia with weight loss, I believe appropriate management was referral for urgent (non-acute) gastroscopy (possibly high suspicion of cancer) as per the relevant [regional] Community Health Pathway.

(v) I believe it was desirable in this case to track [Mrs A's] ultrasound referral to ensure it was completed within a reasonable timeframe and it is unclear if this was done although [Dr C] was conscientious in checking on the referral status on 17 [Month1] and re-faxing the referral. I note [Dr C's] comment that her locum attachment was completed in mid-[Month2] and the practice should have a process in place for ensuring appropriate management of outstanding results and tasks of short-term locums once their attachment is completed.

(vi) I recommend [Dr C] undertake an audit of her clinical notes per the RNZCGP clinic notes review process (Module 2) and report findings and any quality improvement measures to the Commissioner.

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8. On 19 [Month1] the DHB generated a letter addressed to [Dr C] at a surgery she had worked at previously. The letter notes that [Mrs A's] ultrasound had been assigned a priority C (target wait time 6 weeks, estimated wait time 30–38 weeks) with the GP to notify the DHB if the priority was felt to be inappropriate. It appears the letter was eventually received by [the medical centre] as hard copy and notes refer to it being filed by provider [X] on 23 [Month1]. The screenshots I have been provided with do not enable identification of the person viewing the letter when it was received at the practice. Normally, the clinician filing the document is the clinician viewing it. [Dr C] states she has no recall of ever viewing this letter and it has been her standard practice for 30 years to sign and annotate every hard copy document reviewed prior to scanning/filing. She states that had she seen the letter, she would have contacted the DHB to increase the prioritisation of [Mrs A's] scan. There is no signature or annotation on the letter. There has been insufficient information provided in the [medical centre's] response for me to comment further on this issue other than to say it should be evident based on review of the document who has taken responsibility to manage it (either through annotation on the document or as part of the electronic filing process). I would also expect hard copy documents to have date of receipt recorded for audit purposes. If provider X who is recorded as filing the document was also responsible for reviewing the content of the document, I would be mildly to moderately critical that the document was not brought to [Dr C's] attention or, in her absence, another clinician was not assigned to ensure the prioritisation was appropriate. Again, this raises the issue of how the practice manages results and clinical correspondence assigned to a locum who might be in the practice intermittently and for a short period of time.

9. [Mrs A] next presented to [the medical centre] on 31 [Month1] ([Dr B]). Notes read:

- came in with her partner [Mr A]
- has seen by [Dr C]. who rang her to tell her the blood test results
- subclinical hypothyroidism with possible GORD (heavy alcohol drinker in the past)
- has cut down drinking heaps. 2 stubbies of whisky over the last 3 weeks
- loose black stool at times ?peptic ulcer
- today nice brown stool
- ex-smoker. quit 4 years ago. 30 pack years
- low energy still

agrees with the below plan

Plan:

- script as below as per discussion [prescribed levothyroxine and omeprazole]
- review in 4–6 weeks and repeat bloods as per lab form prior

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— weekly weigh herself at home before or after shower in her diary

— review earlier if worse

— if ongoing difficulty swallow with above treatment, refers for gastro to rule out ca.

Weight recorded as 38kg and blood test form provided for use in 4–6 weeks (annotated repeat blood test 2 days before next medical review).

10. [Dr B] states in his response that [Mrs A] appeared unwell and weak at the consultation and although unfortunately not recorded in my records, I recall advising that I felt [Mrs A] should be admitted to hospital that day but this offer was declined by [Mr and Mrs A] who felt that this was not appropriate because it was New Year's Eve. [Dr B] notes [Mrs A] reported issues with difficulty swallowing and intermittent black bowel motions. She had lost a further 3kg in weight over the preceding three weeks. [Dr B] did not examine [Mrs A] as she had had a thorough examination by my colleague previously and she was so unwell I did not feel any other physical examination at that stage would affect my suggested management, which was referral to hospital for further investigation. I proposed a further blood test for anaemia and she was given the form for this. [Dr B] states he felt [Mrs A] may have a serious condition of her upper gastrointestinal tract. I was aware of her history of high alcohol intake and acknowledge that that may cause upper gastrointestinal problems including inflammation and bleeding. The possibility of cancer was also discussed with advice that if the symptoms persisted despite treatment, referral to a gastroenterologist would be required in preference to the awaited liver ultrasound. Omeprazole was prescribed to treat possible upper GI inflammation causing bleeding and difficulty swallowing, and thyroxine prescribed in case her reduction in thyroid activity was contributing to her lack of energy. Safety netting advice was provided for [Mrs A] to present before the planned 4–6 week review if her symptoms worsened.

11. Comments:

(i) [Mrs A] apparently looked very unwell with deterioration in symptoms since her previous review on 10 [Month1]. New symptoms of dysphagia and possible intermittent melaena were recorded although there was no melaena currently. In this clinical scenario, I would expect recording of vital signs to ensure haemodynamic stability in case of a concealed GI bleed, and review of previous abdominal findings (eg increased epigastric tenderness to suggest active peptic ulcer disease). I do not believe the examination three weeks previously removed the need to re-examine [Mrs A], particularly in light of her newly recorded significant symptoms. I believe the failure by [Dr B] to examine [Mrs A] on this occasion would be met with moderate disapproval by my peers whether or not hospital admission was considered, and certainly once admission was declined by [Mrs A].

(ii) I believe acute specialist referral required consideration given the possible history of recent intermittent melaena. [Mrs A] was at increased risk of oesophageal varices and other significant upper GI pathology because of her alcohol use disorder. If she

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showed signs of haemodynamic instability, I believe acute admission (with patient consent) was mandatory. If her condition was stable with no current evidence of GI bleed and reluctance to attend ED, I believe immediate blood testing was indicated to assess degree of blood loss (if any) to enable further discussion of possible need for acute admission. The combination of progressive dysphagia, weight loss and possible melaena were indications for urgent gastroenterology assessment (if acute admission was declined), ideally with high suspicion of cancer noted. While it was reasonable to commence a PPI in the interim, this trial should not have delayed the gastroenterology referral and it was inappropriate to wait 4–6 weeks before checking blood tests results or deciding whether or not to make the referral. Given the clinical scenario described in the notes, I believe [Dr B's] documented management decisions (trial of PPI, review with blood tests in 4–6 weeks and consider gastroenterology referral if dysphagia persisting) would be met with moderate disapproval by my peers.

(iii) The reported (per [Dr B's] response) declining by [Mr and Mrs A] of the recommendation by [Dr B] that [Mrs A] be referred to ED was a critical factor in her management on 31 [Month1] and I believe most of my peers would expect such a vital piece of information to be fully documented. I am moderately critical of this omission.

(iv) [Dr B] provided [Mrs A] with thyroid replacement treatment. She had subclinical hypothyroidism (normal FT4) with minimally elevated TSH (TSH 4.4 mIU/L, reference range 0.40–4.00). An Uptodate review article notes: The fundamental clinical question regarding patients with subclinical hypothyroidism is whether they should be treated with thyroid hormone (T4 [levothyroxine]). Based upon the natural history alone, most experts and all professional groups recommend that treatment should be started to prevent progression to overt hypothyroidism in patients with serum TSH values ≥10 mU/L. The treatment of patients with TSH values between 4.5 and 10 mU/L remains controversial as relatively short-term randomized trials have not shown a benefit with treatment. While I believe many of my peers would not have treated this degree of TSH elevation, it appears such treatment is regarded as accepted practice by some clinicians.

(v) I recommend [Dr B] review [regional] Community HealthPathways guidance on Dysphagia and Dyspepsia and Heartburn/GORD.

12. [Mrs A] attended [the] ED with her husband on 5 [Month2] because of ongoing deterioration in her condition. Gastroenterology discharge summary includes:

> Admitted with 2/12 progressive dysphagia and 10kgs weight loss. Vomiting with mild upper abdomen discomfort. Minimal fluid intake 1/52 prior to admission.
>
> O/E: EWS 0, Dry MM, cachectic, Virchows node, palpable liver … CT AP showed 7cm distal oesophageal tumour with left gastric necrotic LN mass, left supraclavicular
>
> lymphadenopathy and extensive metastatic disease involving liver and lungs.

Diagnosis was metastatic oesophageal cancer. [Mrs A] had IV vitamin therapy, a nasogastric tube inserted and had some improvement in her swallowing and weight

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gain prior to discharge on 10 [Month2]. However, her condition deteriorated before she could be offered palliative treatment and she was managed with comfort cares (input from Hospice) prior to passing away on 27 [Month2]. I note blood tests on 13 [Month2], in contrast to those a month earlier, showed anaemia, hypoalbuminaemia and severely deranged liver function suggesting rapid progression of her disease over the intervening period. While it is apparent that a referral for gastroenterology assessment made on 10 or 31 [Month1] is unlikely to have altered the rapid course of [Mrs A's] illness (noting even with a high suspicion of cancer referral a wait of up to two weeks for specialist review is expected), the delayed diagnosis impacted on the amount of time [Mrs A] and her family had to adjust to her devastating diagnosis."

The following subsequent advice was obtained from Dr Maplesden:

"I have reviewed the responses received since providing my original advice.

1. [Dr C] response

I acknowledge [Dr C's] recollection that technical issues meant it was quite likely she had to rewrite her notes on 10 [Month1] and this meant the notes were not up to her usual standard. The detail contained in the limited notes provided tends to support [Dr C's] statement and I agree that consideration of these circumstances is warranted. [Dr C] has no recollection of [Mrs A] providing a history of progressive dysphagia and she states she recognises this symptom as a red flag and would certainly have recorded it and taken a different approach to [Mrs A's] management had the symptom been presented. I see no reason to doubt this statement taking into account the detail of the history that was recorded despite the technical issues. I note [Dr C] has completed the recommended clinical notes audit and I have no further recommendations in this regard. I note [Dr C] is firm in her recollection that she was never given the opportunity to review the electronic or hard copies of the DHB letter noting a likely delay in scheduling [Mrs A's] liver ultrasound. The additional remedial measures [Dr C] has undertaken since this complaint are appropriate.

2. [Medical centre's] response

Management of [the DHB's] letter regarding [Mrs A's] ultrasound scan priority (see section 8 in original advice) has been clarified with an accompanying audit log. [X] apparently refers to the workstation being used rather than the staff member handling the result. The letter (hard copy) was scanned by a receptionist on 23 [Month1] (the day it was received). The practice process is for all hard copy clinical correspondence to be scanned on the day it is received then the hard copy placed in the relevant provider physical inbox for review. Once reviewed, the correspondence is returned to reception staff who then place it into the physical inbox of [Dr E]. The response states: *[Dr E] processes the hard copy letters and updates the patient files with any relevant clinical data — such as new classifications, new drugs started etc.* The original hard copy is then shredded. The audit log shows the letter was filed by [Dr E] on 28 [Month1]. The response states: *[Dr C's] version of events does not match the audit logs at all.*

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I disagree with the last comment noted above. What the audit logs show is that the letter was scanned on 23 [Month1] by [the receptionist] and was filed by [Dr E] on 28 [Month1]. It gives no certainty as to what happened to the letter between those dates. I believe it is therefore not possible to prefer the [medical centre's] version of events over [Dr C's] statement and the issue will likely remain unresolved. From an electronic 'audit' perspective, it would be more effective if the provider who is taking responsibility for the correspondence is also responsible for filing the electronic copy and this approach is, in my experience, much more common practice than the process described at [the medical centre].

3. I have reviewed [Dr B's] response and acknowledge his comments. There is no new information provided that changes the comments in my original report."

The following subsequent advice was obtained from Dr Maplesden:

"Per section 11(ii) of my original advice my comments with regards to [Dr B's] management of [Mrs A] on 31 [Month1] included:

I believe acute specialist referral required consideration given the possible history of recent intermittent melaena. [Mrs A] was at increased risk of oesophageal varices and other significant upper GI pathology because of her alcohol use disorder. If she showed signs of haemodynamic instability, I believe acute admission (with patient consent) was mandatory. If her condition was stable with no current evidence of GI bleed and reluctance to attend ED, I believe immediate blood testing was indicated to assess degree of blood loss (if any) to enable further discussion of possible need for acute admission. The combination of progressive dysphagia, weight loss and possible melaena were indications for urgent gastroenterology assessment (if acute admission was declined), ideally with high suspicion of cancer noted.

You have asked for comment on the scenario that [Dr B] did not discuss with [Mrs A] the option of acute hospital admission on 31 [Month1]. I believe that given [Mrs A's] unwellness on that date and her risk factors for serious underlying pathology including active upper GI bleeding, the failure by [Dr B] to explore the option of acute hospital admission would be met with at least moderate disapproval by my peers. If there were signs of haemodynamic compromise or instability (unknown as no assessment in this regard was undertaken), I believe the failure to explore the option of acute admission would be met with severe disapproval by my peers."

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