Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC01571)

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Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. On 26 August 2020 this Office received a complaint from Ms B about the care provided to Ms A[1] by a public hospital[2] (now operated by Te Whatu Ora Waikato) and a medical centre. The complaint concerns the delay in the diagnosis of Ms A's lung cancer, including the failure

[1] Ms B was a friend of Ms A.
[2] Formerly operated by Waikato District Health Board (DHB). On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all DHBs being disestablished. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand (now called Health New Zealand|Te Whatu Ora). All references in this report to the DHB now refer to Te Whatu Ora.

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to ensure that a follow-up chest X-ray was performed and the failure to follow up on a chest X-ray result reported on 5 March 2020.

3. The following issues were identified for investigation:

- *Whether Te Whatu Ora|Health New Zealand provided Ms A with an appropriate standard of care between February 2020 and March 2020 (inclusive).*
- *Whether the medical centre provided Ms A with an appropriate standard of care between February 2020 and March 2020 (inclusive).*
- *Whether Dr C provided Ms A with an appropriate standard of care between February 2020 and March 2020 (inclusive).*

4. Other aspects of Ms B's complaint about other providers in Ms A's care have been dealt with separately.

Background

5. At the time of these events, Ms A was aged in her sixties and was a patient at the medical centre. She was seen by Dr C on several occasions in February 2020, although Dr C was not Ms A's regular general practitioner (GP) at the medical centre.[3]

Consultations 7–21 February 2020

6. On 7 February 2020, Ms A consulted Dr C[4] about a lump on the right-hand side of her neck. Dr C undertook a breast check and took bloods, which were found to be normal. Ms A was observed to have a cough that was producing 'some' phlegm, but her chest was clear and she did not report being unwell.

7. Dr C told HDC that the 'lump' was an enlarged supraclavicular lymph node.[5] Dr C was concerned that the lump could be suggestive of breast cancer and wanted to organise a mammogram for Ms A but this was declined. Dr C recalled Ms A stating that she had never had a mammogram and did not want one. Dr C told HDC that Ms A's refusal was not documented, but she made an ultrasound referral, which she considers demonstrated that she was investigating the lymph node. She accepted that she did not document Ms A's blood pressure, temperature, neurological examination, or a skin check, but recalled that these were normal, as were Ms A's blood tests completed two weeks previously, although there was a mildly raised alkaline phosphatase[6] level.

8. In response to the provisional opinion, Dr C clarified that she was immediately concerned that the 'lump' was a supraclavicular lymph node suggestive of cancer and her thoughts were not restricted to breast cancer alone. At the consultation on 7 February, she took a history and examined Ms A thoroughly. Dr C said that the time taken to do this was about

[3] Ms A was registered with Dr D, who retired in 2020. The medical centre told HDC that patients have the flexibility to see any other doctors within the practice.
[4] Dr C is a long-term locum GP at the medical centre and has worked there as a contractor for several years.
[5] Swollen supraclavicular lymph nodes can occur as a reaction to infection or because of metastatic cancer.
[6] Raised alkaline phosphatase (ALP) is a sign of increased activity in the liver or bones.

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40 minutes in a 15-minute appointment, and this contributed to very little time for comprehensive note writing. She stated that the normal full blood count noted two weeks earlier also made a lymphoma less likely.

9. A subsequent ultrasound report on 10 February 2020 identified a cluster of pathological lymph nodes,[7] and a chest X-ray was recommended.

10. The chest X-ray took place on 10 February 2020 and noted density.[8] A follow-up chest X-ray was recommended for six weeks' time (April 2020). Dr C said that she rang Ms A as she was concerned that the lymph nodes represented an underlying malignancy. Dr C told HDC that given the presence of Ms A's cough, she requested a chest X-ray with a review in five days' time.

11. Dr C discussed the chest X-ray results with Ms A on 14 February 2020 and advised her that she would require a repeat chest X-ray in six weeks' time. Ms A's cough was noted to have lessened, and the neck lump had reduced in size, but Dr C prescribed an antibiotic (amoxicillin) and planned to review Ms A when she had completed the course of amoxicillin.

12. On 17 February 2020, Ms A had pain in the right-hand side of her upper back and she consulted Dr C again. Further blood tests were ordered and pain relief was prescribed. Dr C told HDC that she was concerned that Ms A's back pain might be due to bony metastases,[9] and she discussed this with an Oncology registrar at the public hospital. Further blood tests were recommended, and Ms A was advised to return in one week's time when the course of antibiotics had been completed.

13. At her review on 21 February 2020 with Dr C, it was noted that the supraclavicular lymph node had gone, her cough had resolved, and Ms A reported feeling better with no fever, nights sweats or weight loss. However, her back pain was still present. The treatment plan included a further check of blood results in one week's time and another chest X-ray in five weeks' time.

14. Dr C told HDC that she told Ms A to return for a review if she was experiencing further pain or had new symptoms, or if the lump returned, and that she wanted to review Ms A prior to the chest X-ray in six weeks' time. Dr C said that Ms A was reluctant to plan any further reviews at this stage as she felt that her symptoms had improved. In response to the provisional opinion, Ms B stated that cost would not have been an issue as Ms A had health insurance. Dr C stated that at both consultations on 14 and 21 February she made it clear to Ms A that she required a further chest X-ray and set herself a task reminder.

15. In response to the provisional opinion, Ms B does not accept that Ms A's conditions had improved, as Ms A was admitted to the public hospital on 26 February.

[7] A pathological lymph node is a lymph node that is abnormal in size and consistency.
[8] 5mm nodular in the right mid to upper zone.
[9] Bony metastases are cancer that has spread to a bone from another area in the body.

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16. Dr C said that she consulted with Ms A's previous GP, Dr D, at the medical centre. Dr D retired about a month later, and Ms A's care was transferred to Dr E. Dr C did not have any further consultations with Ms A.

Admission to hospital

17. Ms A was admitted to the Emergency Department (ED) at the public hospital on 26 February 2020 due to pain in the right-hand side of her back (flank), and lower chest and abdominal pain. Ms A reported having a reduced appetite, some nausea, and passing of smaller amounts of urine at her usual frequency. A CT[10] scan of her kidney, ureters and bladder was performed to exclude a kidney stone. While in the ED, Ms A had a chest X-ray, which was interpreted as showing a right lung nodule with no acute changes. She was discharged the same day and advised to follow up with her GP for a repeat chest X-ray as part of her discharge plan from the ED. Ms A was prescribed pain relief and anti-nausea medication.

18. Te Whatu Ora Waikato told HDC that Ms A was managed appropriately and that her presentation was consistent with a possible kidney stone. Te Whatu Ora said that with the benefit of hindsight, while it could be argued that Ms A should have been admitted in February, her normal vital signs and lack of respiratory symptoms meant that an admission would not have been warranted at the time.

19. On 5 March 2020 the chest X-ray taken on 26 February was reported, and the results were provided to the ED clinician at the hospital. It was noted that there were some nodules on both lungs that were concerning, and that cross-sectional imaging should be considered.[11] The report did not have a specific clinician's name on the request and noted that the referral was made by 'Dr Doctor Emergency', and the medical centre was not copied into the report.

20. In response to the provisional opinion, Dr C said that if she had received the result that was reported on 5 March, she would have ensured that Ms A was referred for further investigations urgently.

21. Te Whatu Ora Waikato told HDC that although the chest X-ray result was abnormal, this was not unusual given that it can take 4–6 weeks for findings to clear up following treatment. It was stated explicitly in the ED discharge summary that Ms A should follow up with her GP and have a repeat chest X-ray in six weeks' time.

Events following discharge from hospital

22. Dr C said that as she was not Ms A's registered GP, the discharge summary from the hospital was not sent to her directly. However, the medical centre confirmed that it received the discharge summary on 26 February 2020 and this showed 'no acute changes on CXR'. The medical centre acknowledged that it cannot determine when the discharge summary was

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[10] A computerised tomography (CT) scan combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels, and soft tissues inside the body.

[11] Te Whatu Ora told HDC that due to significant staffing issues within the Radiology service at the time, reporting times were extended. On average, plain reporting film was five days. The eight days taken for Ms A's report included the weekend.

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read for the first time, but the records indicate that the discharge summary was filed by Dr C.

23. Dr C accepts that she did not contact Ms A around the time the chest X-ray was due to be repeated in April. However, Dr C said that she provided appropriate safety-netting advice, including stressing to Ms A the importance of getting the chest X-ray done, discussing the case with Dr D, and setting a task note for a repeat X-ray. Dr C told HDC that she is uncertain why she did not see the reminder she had set herself, and this has been a reminder of the importance of following up on these reminders, and the need for allowing adequate time for administrative tasks. The first COVID-19 lockdown occurred at the end of March 2020, and Dr C's working hours were reduced from one day per week to one day per fortnight. Dr C said that she had no remote access to the medical centre computer from home, and her administrative tasks that normally would be done every week could now be done only every two weeks. Dr C said that the period of lockdown was a stressful time for her and her colleagues, and the many changes that were required may have affected her usual practice of ensuring that she followed up on her task reminders.

24. The medical centre told HDC that all staff had remote access from 6 April 2020, although some staff had issues with access and the medical centre sought the assistance of an IT engineer to resolve these. As per the clinic policy 'Managing Test Results and Clinical Correspondence' (Appendix C), doctors at the medical centre were responsible for their own inbox and tasks and for seeking assistance if needed, and it was the responsibility of individual doctors to follow up their own results and hand over to someone else if required due to illness or leave.

Subsequent events

25. In May 2020, following a further admission to hospital, Ms A was diagnosed with metastatic cancer with involvement of her lungs, lymph nodes, liver, and bones (spine and pelvis). Sadly, Ms A passed away a few weeks later.

Responses to provisional opinion

Ms B

26. Ms B was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and her comments have been incorporated throughout the report where relevant. She stated that she was pleased to see that changes were made as a result of her complaint.

Dr C

27. Dr C was provided with an opportunity to comment on the provisional opinion, and her comments have been incorporated throughout the report where relevant.

Medical centre

28. The medical centre was provided with an opportunity to comment on the provisional opinion, and it advised that it had no comments.

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Te Whatu Ora Waikato

29. Te Whatu Ora Waikato was provided with an opportunity to comment on the provisional opinion, and it accepted the findings. Additional comments made by Te Whatu Ora Waikato have been incorporated throughout the report.

Opinion: Dr C, medical centre, and Te Whatu Ora Waikato

Introduction

30. I take this opportunity to extend my sincere condolences to Ms A's whānau for their loss. I consider that deficiencies in the care provided jointly by Dr C and Te Whatu Ora Waikato contributed to the delay in Ms A's diagnosis. I acknowledge that an earlier diagnosis is not likely to have altered the trajectory of the disease, but it would have provided Ms A the opportunity to contribute to a different and perhaps more meaningful management plan. I have set out the reasoning for my decision below, and I have addressed the care provided in chronological order.

Opinion: Dr C

Documentation of negative findings and refusal of mammogram (7 February 2020) — other comment

31. At the consultation on 7 February 2020, Dr C was concerned that Ms A's enlarged supraclavicular lymph node could be suggestive of breast cancer. Dr C advised Ms A to have a mammogram, but this was declined. Ms A's refusal to have a mammogram was not documented, nor were negative findings such as temperature, blood pressure, skin assessment, and neurological examination.

32. My in-house clinical advisor, GP Dr David Maplesden, advised that best practice would be to document relevant negative findings, and he was mildly critical that Ms A's refusal to have a mammogram was not documented by Dr C. Dr Maplesden advised that in a patient with unexplained lymphadenopathy,[12] questioning about symptoms of lymphoma (such as night sweats, weight loss) is indicated. It is also an accepted principle of clinical documentation[13] to include examination and other relevant clinical findings — including important positives and negatives and details of objective measurements such as blood pressure. Dr Maplesden acknowledged that while Dr C's practice is not being judged against best practice, he remained mildly critical of Dr C's failure to document symptoms associated with lymphoma[14] that could be explored in a patient presenting with unexplained lymphadenopathy.

[12] Swelling of the lymph nodes.

[13] https://www.medicalprotection.org/uk/articles/an-mps-essential-guide-to-medical-records

[14] Lymphoma is a cancer of the lymphatic system, which is part of the body's germ-fighting network.

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33. Dr Maplesden considered that an urgent chest X-ray and fine needle aspiration[15] (FNA) would have been warranted at this point, but he acknowledged that these were considered a few days later.

34. Dr C told HDC that she accepts that she did not document Ms A's refusal to have a mammogram, but she considers that as she had undertaken an examination of Ms A's breasts and referred her for an ultrasound, this demonstrated that she was actively looking for a cause of the lump.

35. Dr C agreed that it is best practice to document negative findings and stated that she did record significant negative findings on that day, including the breast check (no indrawing nipple, no skin changes, axillae[16] NAD,[17] chest clear), in addition to negative findings on 14 and 21 February 2020. Dr C maintained that this demonstrates that she was practising best practice consistently.

36. In response to the provisional opinion, regarding the concern that she did not record all the negative findings and negative history of weight loss at the initial consultation on 7 February, Dr C said that these issues were established during the consultation on 7 February 2020 and were recorded across the two-week period during which she reviewed Ms A. As noted previously, the initial consultation took 40 minutes and left little time for note-taking. When Dr C realised that her earlier notes were incomplete, she added to them appropriately.

37. Dr C said that her immediate response of organising an urgent ultrasound (of a neck lump present for only two days but in a concerning location) and a chest X-ray (within three days) demonstrated her concern that Ms A might have a malignancy. Similarly, the four consultations within two weeks also reflect these concerns. In Dr C's view, to focus on the omission of negative findings at the initial consultation seems somewhat pedantic considering that her notes across those two weeks included these negative findings, plus the urgent ordering and follow-up of two initial investigations within three days, and blood tests.

38. Dr C considers that she is being judged against best practice, despite Dr Maplesden's comment that she is not being measured against 'best practice'. The provisional report acknowledges that at the two following consultations (14 and 21 February, as discussed below) negative findings were included, establishing that as a general proposition Dr C was compliant with this 'best practice'.

39. In addition, Dr C noted that the failure to document Ms A declining a mammogram and the negative findings at the initial 7 February consultation played no part in the delayed diagnosis. Dr C stated that the recording of a significant negative finding is commonly

[15] Fine needle aspiration (FNA) uses a needle and syringe to obtain tissue or fluid from a suspicious mass in the body.
[16] The armpit.
[17] Abbreviation for 'no abnormality detected'.

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affected by the exigencies and time constraints of the day-to-day practice of medicine, as was the case here.

40. I accept that Dr C acted appropriately with regard to organising an ultrasound and chest X-ray, and I acknowledge that Dr C did document her negative findings in relation to the breast check, as well as negative findings in subsequent consultations. The focus of Dr Maplesden's comments are related to the consultation on 7 February 2020 and what was documented in relation to that consultation. Despite Dr C's concern that she is being judged against best practice, I accept Dr Maplesden's advice and agree that at this consultation, Dr C should have documented Ms A's refusal to have a mammogram, and the negative findings such as temperature, blood pressure, skin assessment, and neurological examinations, which appear not to have been recorded in subsequent consultations. I accept that there are time constraints on practitioners, but I consider that it is still important that clinical documentation is both clear and accurate, and I take this opportunity to remind Dr C of the importance of documenting significant negative findings and decisions.

Management of Ms A's symptoms (February 2020) — no breach

41. Ms B told HDC that doctors at the medical centre repeatedly diagnosed Ms A with bronchitis and repeatedly gave her antibiotics with little effect. In addition, Ms B stated that the results of at least one set of blood tests was not followed up with Ms A. In response to the provisional opinion, Dr C told HDC that all blood tests were followed up.

42. Ms A was seen by Dr C between 7 and 21 February 2020. Ms A's symptoms during that time included back pain, a cough, and a lump on the right-hand side of her neck. Dr C arranged for an ultrasound and a chest X-ray, prescribed antibiotics for Ms A's cough, and ordered blood tests.[18]

43. Dr C's last consultation with Ms A was on 21 February 2020, during which it was noted that the supraclavicular lymph node had gone but her back pain was still present, although reportedly this was mild. Ms A's cough had resolved, and she reported feeling better, with no fever, night sweats or weight loss. The treatment plan included a further check of blood results in one week's time and a chest X-ray in five weeks' time. Dr C discussed Ms A's management with Dr D, who was Ms A's usual GP before he retired, and subsequently Ms A's care was transferred to another GP at the medical centre.

44. Dr Maplesden considered that the critical factor at this stage was the improvement in Ms A's symptoms, with resolution of her cough and an apparent almost complete resolution of her lymphadenopathy. Dr Maplesden advised that had there been persistence of either cough or lymphadenopathy, then specialist review and/or further investigations (such as referral for FNA) would have been mandatory due to a high suspicion of underlying malignancy.

[18] Dr C told HDC that Ms A had blood tests performed on 19 February, when the main concern was a raised C-reactive protein, and she was given a laboratory form to get her bloods rechecked a week later. However, on 26 February Ms A presented to the ED at the public hospital.

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45. Dr Maplesden referred to the HealthPathways guidance in discussing the management of neck lumps. While Ms A could have been referred for a respiratory review following receipt of the chest X-ray report, the report did include a recommendation for a repeat chest X-ray (and therefore could be considered specialist advice). In light of this, Dr Maplesden considered that Dr C's management of Ms A was not unreasonable. Dr C told HDC that initially she considered Ms A's supraclavicular mass to be a lymph node and potentially indicative of cancer. As it had been present for only a short time, she wanted to confirm that it was a lymph node. Dr C said that features seen on ultrasound can indicate whether abnormal lymph nodes are reactive or malignant in origin, or due to tuberculosis. There is some debate over the best pathway for investigating neck lumps and lymph nodes, as evidenced by differing guidelines between hospitals. Dr C referred to the HealthPathways[19] guidelines and stated that while she did not order a chest X-ray immediately, her actions were consistent with the pathway. Dr C noted that she was suspicious of malignancy and an ultrasound was indicated in accordance with the pathway. Dr C said that this was also covering for the possibility of infection. Given the short-lived history of these lymph nodes and their possible reactive nature, a trial of antibiotics was also in keeping with the HealthPathways guidelines. The resolution of Ms A's cough and the disappearance of the right supraclavicular lump further suggested to Dr C that these nodes were reactive. In response to the provisional opinion, Dr C said that she did not request an FNA immediately, and this was consistent with the HealthPathways guidance referred to by Dr Maplesden. The lymph node behaved like a reactive lymph node and resolved after a course of antibiotics.

46. I accept Dr Maplesden's advice that Dr C managed Ms A's symptoms adequately at the consultations between 7 and 21 February 2020, and Ms A was referred for the appropriate investigations, including blood tests, an ultrasound, and a chest X-ray, and the blood tests were followed up appropriately. There is no record of Ms A reporting any weight loss at these consultations, and by 21 February 2020 her symptoms were noted to be resolving. In these circumstances, I consider that Dr C acted appropriately and there was no departure from the accepted standard of care in relation to Ms A's symptom management during this time.

Follow-up of chest X-ray — adverse comment

47. On 10 February 2020 Ms A had a chest X-ray, and the reporting radiologist recommended a follow-up chest X-ray in six weeks' time. Dr C told HDC that following her consultation with Ms A on 21 February 2020 she set a task reminder for this to occur.

48. Dr C accepts that she did not contact Ms A at the time Ms A was due for a repeat chest X-Ray in April 2020. Dr C outlined the changes to her working hours that had occurred at that time due to the COVID-19 lockdown, in addition to not having remote access to medical centre notes. The medical centre told HDC that staff had remote access from 6 April 2020. The medical centre provided confirmation that the discharge summary was filed by Dr C.

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[19] Assessment; If history and examination indicate a possible systemic cause, consider a chest X-ray and relevant blood tests; Neck lumps less than 3 weeks' duration are usually due to infection; Do not request FNA for acute lymphadenopathy, lymph nodes less than 10 mm. Management; If a lump is likely to have an infective cause, treat with broad spectrum antibiotics. Recheck in 1–2 weeks for resolution.

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49. The medical centre stated that Dr C was required to follow its policy 'Managing Test results and clinical correspondence' (Appendix C). The policy states that it is the responsibility of individual doctors to follow up their own results and hand over to someone else if required due to illness or leave. The medical centre said that this expectation did not change with staff being given remote access, and doctors at the medical centre are responsible for their own inbox and tasks and for seeking assistance if needed.

50. Dr C told HDC that while she did not action the task reminder, the lack of follow-up from the hospital regarding the chest X-ray reported on 5 March resulted in the delay, and she should not be considered wholly responsible for the delay in the follow-up. Dr C stated that if the chest X-ray result from 5 March had been acted on, then the recall task for a chest X-ray in six weeks' time would have become redundant, and the diagnosis of disseminated cancer made much sooner. Dr C said that had she received the chest X-ray result from the hospital, she would have ensured that a follow-up had been arranged and removed the need for a chest X-ray recall from her task bar.

51. In response to the provisional opinion, Dr C told HDC that unfair focus has been placed on her acknowledged omission when there were more significant causes of the delay in diagnosis — namely, the lack of follow-up by the hospital on 5 March was a major contributor to the delay.

52. Dr Maplesden considered that Dr C's failure to ensure that Ms A underwent a repeat chest X-ray was a critical omission and was a significant contributor to the delay in Ms A's diagnosis. I agree, and I am critical that this did not occur. Dr Maplesden stated:

> 'While it might have been expected that [Ms A] would query why she had not received an appointment for the follow-up chest X-ray once the six-week period had passed, it would also be expected that [Dr C] had a robust process in place for ensuring the referral for a follow-up X-ray was completed in a timely manner. [Dr C] did set a reminder to complete the referral, but this was overlooked by her and there was no referral made for the follow-up chest X-ray. This omission is the basis for my moderate criticism and takes into account as a mitigating factor, the sudden change in processes imposed by the lockdown but noting that at least as of 6 March 2020, [Dr C] was accessing [Ms A's] results and was reminded, per the discharge summary, of the importance of ensuring [Ms A] had a follow-up chest X-Ray organized.'

53. In response to the provisional opinion, Dr C told HDC that she did not have remote access from her home during lockdown. Dr C also stated that she had not referred Ms A in advance for her repeat chest X-ray at six weeks, as on 21 February 2020 she had requested that Ms A book an appointment for a physical review at five weeks, and Ms A would then have been referred for her repeat chest X-ray.

54. The medical centre told HDC that all staff had remote access from 6 April 2020, although some staff had issues with access and the medical centre sought the assistance of an IT engineer to resolve these. The medical centre provided confirmation from its IT team that

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Dr C did have remote access from 6 April 2020. I therefore find it more likely than not that Dr C did have remote access given the evidence provided by the medical centre.

55. While I acknowledge that the COVID-19 lockdown presented considerable operating challenges for both Dr C and the medical centre, I am concerned that Dr C did not follow up on the task reminder for a repeat chest X-ray. I consider that this oversight was one factor that contributed to the delay in Ms A's diagnosis, and I do not accept that providing Ms A with safety-netting advice to have the repeat chest X-ray was sufficient.

Conclusion

56. I am concerned that although a reminder was set by Dr C, she did not ensure that Ms A was referred for a repeat chest X-ray.

Opinion: Te Whatu Ora Waikato

57. I have several concerns about the care provided by Te Whatu Ora Waikato when Ms A was admitted to the hospital's Emergency Department on 26 February 2020, and the follow-up of the chest X-ray report in the following weeks.

26 February 2020 admission — adverse comment

58. As outlined previously, Ms A was admitted to the ED on 26 February 2020 with pain in the right-hand side of her back, lower chest, and abdomen. A CT scan was performed to exclude a kidney stone. A chest X-ray taken in the ED was interpreted as showing no acute changes. Ms A was discharged with appropriate symptom management advice.

59. Te Whatu Ora told HDC that the ED at this time was fully recruited to its budgeted nursing full-time equivalent, but due to sickness and unplanned leave, the department did have deficits in the roster for both the afternoon and evening shift.

60. My independent advisor, emergency medicine specialist Dr Watts, stated that there is no evidence that a senior clinician was involved with Ms A while she was in the ED other than making a request for the CT scan. Dr Watts advised that given that this was a complex case with an unclear diagnosis after imaging, it might be expected that Ms A's case would be discussed with a senior clinician. Dr Watts considered it possible that a senior clinician may have requested a CT of Ms A's chest, based on her not having a classic presentation of renal colic, and also the presence (at this time) of a suspected lung nodule on a recent chest X-ray. Dr Watts also considered that had a senior clinician reviewed the case and viewed the chest X-ray, it is likely that the abnormalities would have been spotted and appropriate care provided at this time. However, Dr Watts acknowledged the issues present in the ED relating to overcrowding, volumes, and workload, and that it is not always possible to obtain timely review by a senior clinician in an otherwise stable patient because of these competing demands. He also noted that it is not unusual or unexpected for junior doctors to miss subtle findings on X-rays.

61. I accept this advice and agree that Ms A should have been reviewed by a senior clinician, given the unclear diagnosis following the chest X-ray. I am critical that this did not occur.

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However, I acknowledge the systemic issues faced by emergency departments, both when these events occurred in 2020 and presently, and the steps taken by Te Whatu Ora to increase the staffing ratios of senior medical officers.

Chest X-ray follow-up — breach

62. The chest X-ray taken on 26 February 2020 was reviewed and reported by a radiologist on 5 March 2020. The report stated that there were 'some nodules on both lungs, larger on the right, which [were] concerning' and that cross-sectional imaging should be considered. Subsequently this report was acknowledged by a clinician in the ED on 12 March 2020. The discharge summary from 26 February was sent to the medical centre but the later X-ray report of 5 March 2020 was not sent to the medical centre, or Ms A.

63. As noted previously, Te Whatu Ora told HDC that it was stated explicitly in the discharge summary that Ms A should follow up with her GP and have a repeat chest X-ray in six weeks' time. In addition, Te Whatu Ora said that there were significant staffing shortages in the Radiology Department and reporting times were extended. Te Whatu Ora also advised that it accepts Dr Watts' findings and has since made improvements in staffing in the ED.

64. In response to the provisional opinion, Te Whatu Ora acknowledged that it did not have a specific guideline for the Emergency Department's management of abnormal results but said that Health New Zealand Waikato does have a policy[20] on electronic result management that covers the organisation. This policy was due to be reviewed on 21 March 2021. Te Whatu Ora advised that the policy will be reviewed urgently to provide guidance to staff in their responsibilities and the acknowledgment of all results.

65. The policy sets out the requirements to ensure the timely electronic acknowledgement of results for Waikato DHB patients (see Appendix E).

66. Dr Watts advised that the delay in the chest X-ray result being reported by Radiology to the ED on 5 March 2020, in addition to the report being acknowledged by the ED a week later on 12 March 2020, is 'less than ideal'.[21] However, he advised that the lack of follow-up from Te Whatu Ora after receipt of the formal report was a serious departure from the accepted standard of care.

67. Dr Watts stated that the appropriate standard of care would be to view the chest X-ray and likely request further imaging. Informing the patient and possibly also their GP would also be considered good care. Dr Watts advised that it is accepted practice that the ordering or referring clinical team (in this case the ED) is responsible for actioning any abnormal pathology,[22] and he is concerned that there was no policy regarding the management of

[20] Issue date 12 June 2018. Review date 21 March 2021.

[21] Dr Watts found that there were delays (not critical) in producing the report and it being acknowledged in the ED. The Radiology delays were relatively minor, and Radiology then provided a report describing the findings and suggesting further imaging and follow-up. It is at this point that the trail has been lost — by ED rather than by Radiology.

[22] The *Cole's Medical Practice in New Zealand* guidelines (2013) are a set of principles intended for all registered doctors working in New Zealand. The guidelines are based on generally accepted standards of practice, and from case experience of disciplinary tribunals, in accordance with advice from the Health and

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significantly abnormal test reports in the ED.[23] Dr Watts considers that a suitable policy would address the process of handling test results that are received by the ED, and the responsibility of following up abnormal results, contacting the providers, and ordering further investigations as required. I accept this advice. Te Whatu Ora had a responsibility to inform Ms A of the abnormal result that had been reported and the recommendation for further imaging. In addition, Te Whatu Ora should have either arranged the further scan, or explicitly communicated to the medical centre that this additional imaging had been recommended. This omission was a further factor that contributed to the delay in diagnosis for Ms A. I do not accept that Ms A should have been expected to follow up the repeat chest X-ray herself, as suggested by Te Whatu Ora.

68. I acknowledge that there was a policy in place at the time for the management of electronic results, and I am critical that this was not followed by staff. This policy is now well overdue for review, and I will include a recommendation that Te Whatu Ora address this.

Conclusion

69. For the reasons set out above, I find that Te Whatu Ora Waikato failed to inform the medical centre and Ms A of the chest X-ray result that recommended further cross-sectional imaging. Accordingly, Te Whatu Ora breached Right 6(1) of the Code.[24] I am critical that Ms A was not reviewed adequately by a senior medical officer given her presentation on 26 February 2020.

Opinion: Medical centre — no breach

70. The medical centre was responsible for providing services in accordance with the Code. Dr C was employed as a locum at the time of these events.

71. Dr Maplesden advised that the medical centre had a practice policy ‘Managing Test Results and Clinical Correspondence’ that appears consistent with those reviewed from other practices and is fit for purpose. Dr Maplesden also advised that the provision of remote access to all staff members at the medical centre within two weeks of lockdown was a reasonable action to mitigate the risks resulting from the impositions of the lockdown.

72. In this case, I consider that the deficiencies in Ms A’s care were individual failures rather than systemic, and therefore I find that the medical centre did not breach the Code.

Disability Commissioner. This includes eight key principles for managing clinical investigations. Principle 3 provides the following requirement: ‘If you are responsible for conducting a clinical investigation you are also responsible for ensuring that the results are appropriately communicated to those in charge of conducting follow up, and for keeping the patient informed.’

[23] In response to the provisional opinion, Te Whatu Ora provided a copy of the policy ‘Electronic Result Acknowledgement: The Responsibilities of Senior Medical Officers and the Delegation of Authority to Resident Medical Officers and Others’ that was in place at the time of these events.

[24] Right 6(1)(f) states: ‘Every consumer has the right to the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive.’ This includes the results of tests.

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Changes made since events

73. The medical centre told HDC that the following changes were made because of this complaint:

- A meeting with all doctors was held to discuss where they could improve their practice, whilst recognising that they were working under COVID-19-related restrictions at the time of the events. The meeting involved a debriefing from each doctor and a review from the medical centre's point of view.
- The medical centre reviewed its methods of communication and put in place further safety nets to ensure that follow-ups occur within the recommended timeframe. All staff have a remote access login and have access to IT support if required.
- There are multiple channels for staff communication, including in-person, Zoom meetings, a group chat, email, and the MedTech task function.
- Staff are reminded to ensure that at every contact with a patient, the tasks on MedTech are looked at and addressed, either by sending a reminder to the staff member who added the task or a direct follow-up.

74. Dr C told HDC that as a result of the complaint, she made the following changes:

- Important repeat tests are placed under 'recalls' instead of 'tasks', as nurses have more time allotted for checking recalls and are present in the medical centre daily during business hours;
- A clinical alert is placed on a patient's notes if there are any significant concerns, rather than just having a conversation with the registered GP, so that any GP reviewing the patient is aware of such concerns more readily;
- Any new significant morbidity in a patient is discussed at a weekly huddle.

75. Te Whatu Ora told HDC that because of this complaint, it made the following changes:

- The ED has significantly increased the staffing ratios of senior medical officers and registered nurses for each shift to ensure that adequate and appropriate staff are available to see and treat patients.
- The Radiology Department continues to recruit radiologists, but there is a national shortage of radiologists. Plain film reporting capacity has been increased with the use of external outsourcing providers.

Recommendations

76. I recommend that Dr C:

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

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b) Present this case as an anonymised case study to her peers. Evidence that this has been done is to be provided to HDC within six months of the date of this report.

77. I recommend that Te Whatu Ora Waikato:

a) Provide a written apology to Ms B for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms B.

b) Review the Electronic results policy. A copy of the policy is to be sent to HDC within six months of the date of this report.

c) Provide training to ED staff in relation to the above policy. Confirmation of the training is to be sent to HDC within six months of the date of this report.

Follow-up actions

78. A copy of this report with details identifying the parties removed, except Te Whatu Ora Waikato and the advisors on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name in covering correspondence.

79. A copy of this report with details identifying the parties removed, except Te Whatu Ora Waikato and the advisors on this case, will be sent to the Royal Australian and New Zealand College of General Practitioners, Te Whatu Ora|Health New Zealand, and Te Tāhū Hauora|Health Quality & Safety Commission and 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:

'**FILE NUMBER** : C20HDC01571

DATE : 29 July 2021; **Addendum 8 November 2022 (s4); Addenda 24 April 2023; Addendum 27 September 2023 (s 11(ii))**

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1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a practising general practitioner. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her friend, [Ms A], by staff of [the medical centre] and Waikato DHB. 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.

2. I have reviewed the following information:

- Complaint from [Ms B] — [close friend and latterly carer of Ms A (dec)]
- Responses from [Dr C], of [the medical centre]
- [Medical centre] clinical notes
- Responses from Waikato DHB clinical staff involved in [Ms A's] ED assessment on 26 February 2017
- Associated DHB clinical documentation ([public hospital])
- **Responses to this advice were received from [the medical centre] [and] [Dr C] and have been incorporated into this advice.**

3. [Ms A] (aged in her sixties) was diagnosed with probable disseminated lung cancer in [2020] following several months of respiratory symptoms and weight loss. She deteriorated rapidly following her diagnosis and sadly succumbed to her disease on [date] before any definitive treatment was commenced. [Ms B] has provided a detailed complaint which relates to many aspects of [Ms A's] diagnosis and care by multiple providers. The main areas relating to GP involvement in [Ms A's] care are:

(i) delays in the diagnosis of [Ms A's] lung cancer, including failure to ensure a follow-up chest X-ray was performed and failure to realise the significance of [Ms A's] unexplained weight loss in early 2020

(ii) poor management of [Ms A's] pain relief at end of life

Specifically, [Ms B] states: *In 2020, [Ms A] was repeatedly diagnosed as having bronchitis by doctors at [the medical centre] and repeatedly given antibiotics (which seemed to have little effect apart from inducing nausea). She was rapidly losing weight*

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from early 2020, reporting in May that a doctor at [the medical centre] had recorded a loss of 10kg since the last recording there. In addition, there was at least one lot of blood tests (almost certainly more) and, I believe, also chest X-rays, since the beginning of the year, with, it appears, no follow up on the results from the medical practice she attended.

5. On 7 February 2020 [Ms A] was reviewed by [Dr C]. Notes include:

2 days ago noticed a lump R side neck, developed overnight. Had a cough productive of some phlegm but not unwell. No other lumps, bumps, spots or health problems. Non smoker. Plan u/s neck lump ? dx

Breast check no indrawing nipple, no skin changes, generally lumpy breast bilat. Axillae NAD. Chest clear. Bloods OK [routine blood tests taken 22 January 2020 showed normal blood count and differential and mild isolated elevation in ALP (139 U/L — range 40–130) — to be repeated in 12 months].

[Dr C] notes in her response that she is a long-term part-time locum at [the medical centre] working [one day a week] only. She felt the lump was a right supraclavicular lymph node and was concerned about the possibility of underlying breast malignancy. She states she offered [Ms A] a mammogram but this was declined. However a recommendation for urgent ultrasound of the node was accepted and arranged. [Dr C] states there were additional assessment findings not documented including normal temperature and blood pressure and unremarkable skin assessment and neurological examination.

Comment: Best practice would be to document relevant negative findings and I am mildly to moderately critical the issue of patient declining an important clinically relevant investigation was not documented. In a patient with unexplained lymphadenopathy, questioning about symptoms for lymphoma (eg night sweats, weight loss) is also indicated. A review article on lymphadenopathy includes: *Supraclavicular lymphadenopathy is associated with a high risk of malignancy. In two studies, malignancy was found in 34 and 50 percent of patients with this presentation; the risk was highest in those over the age of 40. Right supraclavicular adenopathy is associated with cancer in the mediastinum, lungs, or esophagus. Left supraclavicular adenopathy ("Virchow's node") suggests abdominal malignancy (eg, stomach, gallbladder, pancreas, kidneys, testicles, ovaries, lymphoma, or prostate)*[1]. Given [Ms A's] age and concurrent symptom of cough, I believe referral for urgent chest X-ray was indicated at this point. Ultrasound is not recommended in local management pathways as initial investigation of a neck lump as it is of limited diagnostic value, with fine needle aspirate (FNA) the preferred investigation if the nature of suspected persistent (>3

[1] Ferrer R. Evaluation of peripheral lymphadenopathy in adults. Uptodate. Literature review current through June 2021. www.uptodate.com Accessed 29 July 2021

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weeks) lymphadenopathy requires further evaluation[2]. As noted below, consideration was given to ordering of a chest X-ray and FNA a few days later.

Addendum 24 April 2023: A further response from [Dr C] expresses concern at two issues I have raised above. The first relates to my comment regarding recording of relevant negative findings representing best practice in clinical documentation. This is an accepted principle of clinical documentation (for example an MPS publication on good clinical documentation [3] includes: *Examination and other relevant clinical findings — include important positives and negatives and details of objective measurements such as blood pressure*) and while I agree [Dr C's] practice is not being judged against 'best practice' I maintain the statement is accurate and was made on this occasion with reference to symptoms associated with lymphoma that might be explored in a patient presenting with unexplained lymphadenopathy. I acknowledge relevant negative findings were recorded in relation to the breast assessment. The second issue raised is the mild to moderate departure attributed to [Dr C's] failure to record discussion of mammogram and [Ms A's] refusal of this investigation. [Dr C] confirms she was considering breast pathology as a potential cause of [Ms A's] supraclavicular mass but the unremarkable breast examination was somewhat reassuring. Referral was initiated for ultrasound of the mass and while mammogram was considered, given the normal breast assessment and [Ms A's] declining of that investigation, [Dr C] felt it was reasonable to defer further discussion of mammography until the nature of the mass was more clearly defined. I believe these management decisions were reasonable under the circumstances and it was absence of documentation of the mammogram discussion rather than the clinical decision per se of which I was critical. On reflection, noting [Ms A] did not have any specific breast symptom and a normal breast assessment, presentation with isolated supraclavicular lymphadenopathy (rather than axillary lymphadenopathy) would be a somewhat unusual presentation of breast cancer. While I maintain it is accepted practice to have documented the discussion and declining of a mammogram in the scenario described, I accept I may have been overly harsh in my initial criticism of [Dr C's] omission and the documentation omission might be more appropriately described as being a mild departure from accepted practice.

6. Ultrasound was performed later on 7 February 2020 with report concluding: *There is a cluster of pathological lymph nodes in the right side of the neck in the supraclavicular region as noted above. These measure up to 12 mm short axis diameter. The differential diagnosis lies between reactive nodes or malignancy such as lymphoma. Further investigation is recommended. I would suggest starting with a chest X-ray. Consideration should be given to an FNA biopsy with ultrasound guidance, and further imaging would be guided by the cytological and histological findings.* [Dr C] telephoned [Ms A] with the result when she reviewed it on 10 February 2020 and urgent chest X-ray was arranged with review scheduled for five days. The chest X-ray report dated 10

[2] Community HealthPathways. Neck Lumps in Adults. Accessed 29 July 2021
[3] https://www.medicalprotection.org/uk/articles/an-mps-essential-guide-to-medical-records Accessed 24 April 2023

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February 2020 concluded: *There is a small volume of fluid within the lung fissures but no discernable pleural effusion. The other finding is a 5 mm nodular density in the right mid to upper zone. No prior imaging for comparison. No consolidation. A follow up chest X-ray is warranted in 6 weeks' time to assess for resolution of these findings.*

7. [Dr C] reviewed [Ms A] on 14 February 2020 and discussed the results including requirement for repeat chest X-ray in six weeks. Notes include: *has had cough since mid-December associated with feeling tired, now cough has lessened, feeling a bit better and thinks the R supraclavicular lymph nodes has reduced in size PF 330, chest clear all zones. R supraclavicular Ns less prominent. Plan: course of amoxicillin for 1 week then review whether to refer to respiratory clinic — phone to let me know.* [Dr C] states her rationale for these management decisions was that she felt the lymphadenopathy may have been reactive and related to the cough, and a trial of antibiotics to determine response was a reasonable option.

8. In the early hours of 17 February 2020 [Ms A] attended [an accident and medical clinic] with new onset right lower back pain. Notes include: *coughing a lot but ab has settled it, wheezing at times …* Vital signs were normal and cardiorespiratory and abdominal examination unremarkable. Diagnosis was possible pleurisy with plan for trial of NSAID (Naproxen) and a period of observation (stable) prior to discharge. [Ms A] returned for review by [Dr C] later on 17 February 2020. History of back pain was obtained and initial response to Naproxen. Notes include: *o/e tender R 7th rib posteriorly, pulling sensation in this area with thoracic rotation. dx ? musculoskeletal pain ?? referred pain from epigastrum ? bony met. R supraclavicular node has reduced though, currently on amoxil. Recheck bloods, if still getting pain in 1 week refer for further invx, if pain worse then urgent review.* Blood tests dated 19 February 2020 showed normal blood count and differential, further increase in ALP to 170 U/L, mild increase in globulins and decrease in albumin, normal amylase but elevated CRP (76 mg/L, range 0–8).

9. On 20 February 2020 a practice nurse has recorded: *MD reviewed bloods, requested [Ms A] tci for review, contacted and appt made. Symptoms are improving.* [Dr C] reviewed [Ms A] on 21 February 2020 noting: *R supraclavicular lymph nodes reduced/gone, cough stopped, feeling better but still tired, never had sweats, fever or weight loss … still has back pain which is a niggle.* Travel history was obtained including contact with someone coughing on her most recent flight (December 2019) and her cough developing shortly after this. A previous history of renal stones was also noted although [Ms A] felt her back pain was different to previous renal colic (dipstick urinalysis undertaken by [Dr C] and was normal). [Dr C] states: *The plan at this stage was to get an xray of her upper back, recheck her bloods in 1 week and repeat the chest xray in 5 weeks. As previously advised, after the initial presentation of her enlarged supraclavicular lymph nodes, she was to have a low threshold for review for her pains, current symptoms and any new symptoms arising. At this stage she was reluctant to plan any review follow ups as she felt she had improved and she had paid for several review consultations to date.* A form was provided for blood tests and spine X-ray. At

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this stage, [Dr C] states she discussed [Ms A's] management with her usual provider ([Dr D]) who retired shortly after with [Dr E] becoming [Ms A's] registered provider.

10. Comment: I believe the critical factor at this point was the apparent improvement in [Ms A's] symptoms (as documented) with resolution of her cough and apparent almost complete resolution of her lymphadenopathy. In this context, it was reasonable to assume there was most likely an infective cause for her symptoms and the lymphadenopathy had been reactive. Had there been persistence of either cough or lymphadenopathy, I believe specialist review and/or further investigations (such as referral for FNA) was mandatory, with high suspicion of underlying malignancy. The previously cited HeathPathways guidance includes: *a neck lump that has been present for more than 3 weeks needs investigation, unless it is shrinking. Lumps less than 3 weeks duration are usually due to infection … Do not request FNA for acute lymphadenopathy, lymph nodes smaller than 10 mm, stable long-term palpable lymph nodes, or diagnosis of stable lipoma.* I believe some of my colleagues might have referred [Ms A] for respiratory review, or sought specialist advice, following receipt of the chest X-ray report (chest nodule identified in a patient with pathological right supraclavicular lymphadenopathy) but I acknowledge the recommendation in the radiologist report (which might be regarded as specialist advice) for repeat chest X-ray in six weeks initially, and the clinical information provided to the radiologist included reference to [Ms A's] supraclavicular lymphadenopathy. Under the circumstances, I believe [Dr C's] management of [Ms A] to this point was not unreasonable but I recommend she review the cited HealthPathways guidance on management of neck lumps. However, the follow-up chest X-ray I believe was a critical investigation that required tracking to ensure it was completed at the recommended interval (due early April 2020). [Dr C] notes in her response: *I had made it clear to [Ms A] that she needed a repeat chest xray in 6 weeks after the initial CXR, at the 14th February consultation and again on 21st February. I set myself a reminder note that a repeat CXR was needed too.* I have not been provided with confirmation of the reminder documentation (eg Task Manager documentation).

Addendum 24 April 2023: I have since been provided with confirmation that on 21 February 2020 [Dr C] set a reminder for [Ms A's] chest X-ray and on 14 February 2020 she had set a reminder: *Consider LN bx, respiratory referral.*

11. The thoracic spine X-ray dated 21 February 2020 showed degenerative changes in the lower thoracic spine with *florid anterior R side osteophyte formation producing ankylosis in mid thoracic region.* There were no findings to suggest bony metastatic disease. [Dr C] quite reasonably felt these changes could have accounted for [Ms A's] back pain which now appeared to be settling. [Dr C] states she did not receive subsequent discharge summaries from ED or [the public hospital] (see below — ED discharge summary included reference to a new chest X-ray as showing no acute changes which might have been perceived as reassuring) as she was not [Ms A's] registered provider and she did not see [Ms A] again. New Zealand entered Covid level 4 lockdown on 25 March 2020. [Dr C] states that following lockdown: … *my working hours per week were reduced from 1 day per week to 1 day per fortnight. This occurred*

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just prior to the planned repeat chest X-ray. I had no remote access to the Medical Centre computer from home and my administrative tasks that would normally be done every week could now only be done every two weeks. I am uncertain why I did not see the reminder I had set myself for the repeat chest xray and this has been a salutary reminder of the importance of following up on these reminders, and the need for adequate time for administrative tasks. The period of lockdown was a stressful time for me and my GP colleagues, and the many changes that were required may have affected my usual practice of ensuring that I followed up on my task reminders. The failure to ensure [Ms A] underwent a repeat chest X-ray was a critical omission and I believe was a significant contributor to the delay in [Ms A's] diagnosis. The sudden change in general operating processes as a result of the Covid situation may have influenced [Dr C's] usual practices and I regard this as a mitigating factor. It is also quite possible that the chest X-ray, even if requested at the appropriate time, may have been deferred due to reduced access to community and hospital radiology providers for other than urgent imaging during level 4 lockdown. However, I believe the failure by [Dr C] to facilitate [Ms A's] follow-up chest X-ray at the recommended time interval represents a moderate departure from accepted practice and I would be somewhat more critical if the overall clinical picture (from [Dr C's] perspective at the time of her last contact with [Ms A]) had not appeared to be resolving, and noting the disruption caused by the Covid lockdown.

(i) Addendum 24 April 2023: In her later response, [Dr C] states: *Concerning the remarks about ensuring that a chest X-ray got repeated six weeks later, I thought I had safety netted the situation by*

1/ stressing the importance of getting this investigation done with [Ms A]

2/ having a discussion with her registered GP, [Dr D]

3/ setting a task note for a repeat chest X-ray

[Dr C] acknowledges she *personally did not contact [Ms A] around the time* [the chest X-ray] *was due for repeat* and she discusses the impact of the Covid lockdown and change in her consulting pattern (to alternate [weeks]) may have impacted on her missing the task set for repeating the chest X-ray. She states also she did not have remote access to patient notes whereas the [medical centre's] response indicates such access was facilitated during the lockdown. This is of some relevance regarding the extent to which practice processes may have contributed to the oversight. The changes made to processes during the various lockdown levels (presented in the [medical centre's] response) appear consistent with accepted practice at the time, including dividing of staff into two separate 'bubbles' working alternate shifts. This apparently resulted in [Dr C] attending the practice only one day per fortnight and presumably having to action all her results, recalls etc on this one day if she did not have remote access and there was no provision for another provider to manage her tasks and inbox between her attendances at the practice. The [medical centre's] response notes also it is the responsibility of the GP to assign the task of reviewing their results to another provider if required. I do not believe it was satisfactory for [Dr C's] tasks and inbox results to go unaddressed for two weeks at a time if this was the

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case, but the situation should perhaps be confirmed with [Dr C] and/or [the medical centre] including any steps taken to mitigate the clinical risks associated with the situation. Nevertheless, there is no new information in the responses that alters my opinion that the failure to recall [Ms A] for repeat chest X-ray as previously recommended was a moderate departure from accepted practice (although systemic factors could be more relevant in the oversight than originally considered). I acknowledge [Dr C's] comments that in fact the recall became redundant once the chest X-ray from 26 February 2020 was formally reported (see below) and I agree the failure by [public hospital] clinicians to follow-up the result appropriately (including informing [Dr C] or another [medical centre] clinician of the result) was a critical oversight on their part. However, this is a hindsight observation with this information not known by [Dr C] at the time her recall of [Ms A] was overlooked. [Dr C's] response indicates she has reflected at length on this complaint and the remedial actions she has undertaken, as listed in her response, are appropriate and should limit the risks of a similar oversight occurring in the future.

(ii) Addendum 27 September 2023. Further information was received from [the medical centre] including an IT report, inbox audit results and a copy of the practice policy on management of tests results.

- **The IT report notes an AD (?Active Directory) account was first created for [Dr C] on 20 September 2018 and remote access was enabled for all staff on 6 April 2020. There were no major access issues raised by staff between March and May 2020 but IT support was readily available should such issues be encountered. [Dr E] states also: *Some [medical centre] staff had remote access prior to lockdown*. It remains unclear to me if [Dr C] was one of those staff members who had remote access prior to lockdown, or whether she gained remote access from 6 April 2020. Nevertheless, I believe the provision of remote access to all staff members within two weeks of lockdown was a reasonable action to mitigate the risks resulting from the impositions of the lockdown.**
- **The practice policy on management of tests results appears consistent with those I have reviewed from other practices and is fit for purpose. It appears [Dr C] was responsible for managing her Inbox unless she deputized this to another provider or had an unplanned absence.**
- **Inbox audit report has been provided and confirms that on 6 March 2020 the [public hospital] discharge summary received 26 February 2020 (see s13 below) was initialled [and] was [Dr C's] service code. This has been previously discussed in the addendum in s14.**
- **As previously noted, the discharge summary was somewhat reassuring for [Dr C] in that it reported there were no new acute changes in the chest X-ray taken at that time (although subsequent formal report was concerning), and it emphasized [Ms A] had been instructed by the MO to ensure she had the follow-up X-ray in the six-week timeframe (from 10 February 2020) previously discussed with [Dr C]. While it might have been expected that [Ms A] would query why she had not**

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received an appointment for the follow-up chest X-ray once the six-week period had passed, it would also be expected that [Dr C] had a robust process in place for ensuring the referral for follow-up X-ray was completed in a timely manner. [Dr C] did set a reminder to complete the referral but this was overlooked by her and there was no referral made for the follow-up chest X-ray. This omission is the basis for my moderate criticism and takes into account as a mitigating factor the sudden change in processes imposed by the lockdown but noting that at least as of 6 March 2020, [Dr C] was accessing [Ms A's] results and was reminded, per the discharge summary, of the importance of ensuring [Ms A] had a follow-up chest X-ray organised.

12. On 26 February 2020 [Ms A] attended [an accident and medical clinic] with persistent right sided neck and back pain and lack of energy with mild nausea. Notes include:

No weight loss No fever or rigors, Last 2 days eating less … No cough, runny nose, no chest pain and not SOB … Vital signs were normal and respiratory and abdominal examination unremarkable. The attending doctor reviewed [Ms A's] recent blood results and noted: *Discussed with Medical registrar. ? renal calculus with infection given raised CRP and unwell with this. For review with ED physicians, ? CTU ? underlying infection.* [Ms A] was referred to [the] ED for medical review.

13. ED discharge summary dated 26 February 2020 includes history as: *2 weeks ago had persistent cough with thick green sputum. Given doxycyline by GP. CXR showed R lung nodule — for 6 week CXR follow up under GP. 1 week later developed RL chest/R flank pain … No fever. Some nausea, reduced appetite. Particularly poor sleeps past few days with ongoing symptoms …* Vital signs were normal and physical examination unremarkable. The summary includes: *No acute changes on CXR. CTKUB — no renal stones, small adrenal nodule (in keeping with a benign adrenal adenoma), otherwise normal solid organs … bloods: normal FBC, CRP 8.4 (reduced from 76), creatinine 93 (100 in 2017) LFTs (raised ALP otherwise normal) lipase normal.*

Plan: — symptom management at this stage. (paracetamol, ibuprofen, antinausea and codeine)

— if ongoing symptoms not improving over the next few weeks followup with your GP for repeat review.

— ensure you follow through with the follow up chest x ray at 6 weeks.

— if the pain is getting significantly worse and the above medications are not helping, seek further medical attention

14. The chest X-ray was formally reported on 5 March 2020. There was no copy sent to the GP and apparently no contact with the GP regarding the result. The radiologist did not have automatic access to the previous images from 10 February 2020. The report reads:

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CLINICAL INDICATION:
3 weeks ago had infection, now has posterior chest/flank pain query fluid accumulation

FINDINGS:
No previous

Heart size enlarged, mediastinal contour are normal. There are some nodules seen within both lungs, larger on the right, which are concerning. Small right posterobasal focus of consolidation. No left sided effusion seen.

Consider cross-sectional imaging to further assess

Comment: My interpretation of this report is that referral for CT (cross-sectional imaging) is being recommended. I believe this report should have been forwarded to [Ms A's] GPs, particularly if the referring clinician was not going to action the report, noting the comment in the discharge summary of "no acute changes". I recommend independent advice is obtained from an ED specialist to comment on [Ms A's] management in ED on 26 February 2020, but in particular the management of the formal X-ray report (noting to the expert that the GP did not receive a copy of the report and there was no contact from an ED clinician in relation to the report). I would expect [Dr E], as [Ms A's] registered GP, to have reviewed a copy of the ED report. While [Dr E] had not organized the initial chest X-ray, I believe best practice would be for him to have taken some steps to ensure scheduling of the follow-up chest X-ray was in place (noting specific reference to this in the discharge summary) and I am mildly critical if this was not done. However, I cannot state that had he checked with [Dr C] a reminder for the X-ray was in place, this would have affected [Dr C's] later oversight.

Addendum 24 April 2023: [Dr E], per his legal representative, has clarified that he did not receive a copy of the ED discharge summary, and the PMS shows the summary was acknowledged by [Dr C] on 6 March 2020. The discharge summary was forwarded to [Dr C] because of her recent repeated consultations with [Ms A]. It seems reasonable to me that the discharge summary was forwarded to [Dr C] under the circumstances (retirement of current registered GP imminent, [Dr C] managing current respiratory issues referred to in the discharge summary), and it is apparent [Dr C] reviewed and filed the discharge summary. I therefore retract any criticism of [Dr E] in relation to ensuring follow-up of the chest X-ray. Filing of the discharge summary might have served as a reminder to [Dr C] that [Ms A] required a follow-up chest X-ray but by this stage a formal reminder had been entered into the PMS in any case and the follow-up X-ray was not yet due.'

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Appendix B: Clinical advice to Commissioner

The following advice was obtained from emergency medicine specialist Dr Martin Watts:

'Report To: The Health and Disability Commissioner

Complaint: [Ms B]/[Ms A]

Date: 5th January 2022

Reference: C20HDC01571

Report provided by Martin Watts, MB,ChB,DCH, FACEM, Emergency Medicine Specialist. Emergency Medicine Consultant with 15 years clinical practice at Specialist level, including time as Emergency Department Clinical leader.

I have read the guidelines for Independent advisors and have followed them. I am not aware of any conflict of interest related to this case.

Thank you for referring this case for review. I will confine my report to the care provided by the Emergency Department.

My findings are based on the clinical notes and results/reports provided to me by the HDC, including a copy of the original complaint (redacted).

1. The management of [Ms A] in ED on 26 February 2020;
   a. There has been a reasonable clinical history taken and documented and a good clinical exam documented. This is of acceptable standard.

      A provisional diagnosis of renal colic has been made despite little objective evidence of this apart from a previous episode 20 years ago. Investigation by means of CT was appropriate as this was suspected. However the CT report came back and did not show any evidence of renal colic and the work was essentially stopped at this point with no clear diagnosis made, although expectant care was decided upon. This would be acceptable practice in the circumstances as the patient was stable.

      A more senior clinician might have added a CT Chest to the request on the basis of this being not a classic presentation of renal colic and also the presence (at this time) of a suspected lung nodule on a recent chest X-ray.

      It is not unusual or unexpected for Junior Doctors to miss subtle findings on X-rays such as the chest X-ray in this case, again this is not unexpected.

      There is no documentation to support that a Senior Clinician being involved with the patient whilst in ED on this date, apart from on the request form for the CT-KUB ("d/w [name] (ED SMO)"). With a complex case and an unclear diagnosis after the imaging it might be expected that the case would be discussed with an ED Senior Clinician.

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b. Accepted practice would be that cases should ideally be discussed or reviewed by a Senior Clinician and this documented. This is especially the case where there have been multiple previous attendances to Doctors in a short space of time and there is no clear diagnosis. This would likely be viewed as a mild departure of care.

c. Due to ED overcrowding, volumes and workload, it is not always possible to obtain timely review by an ED SMO in an otherwise stable patient due to competing demands. This would be a common occurrence in many New Zealand EDs and as such would not be viewed as different from many peer hospitals.

d. There should be access to discuss cases with a Senior Clinician and review where a diagnosis is unclear. Had a Senior ED Doctor reviewed the case and viewed the chest X-ray, it is likely that the abnormalities would have been spotted and appropriate care provided at this time. Junior medical staff should be reminded to discuss such patients with a senior colleague, and document the results of this discussion.

2. The management of any treatment and follow up care provided to [Ms A] following her discharge from ED on 26 February 2020

   a. There does not appear to be any follow up care provided by the ED after the 26 February, other than reiterating to the patient to follow up with their own GP and attend for follow up chest X-ray as arranged.

   b. Given that a worrying report became available to the ED on 5 March and this was not actioned, this is a serious departure from [the] standard of care.

   c. This would be viewed as a failure to follow up appropriately by peers.

   d. A clear policy or guide for dealing with abnormal results and documentation relating [to] this.

3. The management of [Ms A's] formal X-ray reported on 5 March 2020, including communication with other providers.

   a. The formal chest X-ray report was filed/resulted on 5th March; this is over a week after the film was taken. This is longer than ideal. The report has been acknowledged a further week later by "[name] on 12th March" but no action apparently taken. A further week between receiving the report and acknowledging it is less than ideal. The report stated that further cross sectional imaging (scanning) should be considered. The standard of care would be to view the X-ray and likely request further imaging. Informing the patient and possibly the GP would be considered good care.

   b. This is a serious departure from the standard of care.

   c. This would be viewed as a failure of the system by peers. It is accepted practice that the ordering or referring Clinical team (in this case the ED) is responsible for actioning any abnormal pathology. See the list of references provided at the end of this response.

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d. A clear policy or guide for dealing with abnormal reports and documenting this.

4. Any other matters in this case that you consider warrant comment

   Follow up of abnormal test results is very common in Emergency Medicine. It is surprising that a large Hospital in a busy DHB does not appear to have a policy regarding the management of significant abnormal test results. **(If Waikato DHB does already have such a policy or guide, I would suggest a copy be provided to the HDC and the document reviewed to see if this was followed.)** If there is no policy or guide, then one should be considered.

In the absence of a policy or guide, it would be appropriate for the ED to provide the HDC with some details of its system for viewing, acknowledging and acting on any results which arrive after the patient has left ED from their visit.

On the (redacted) copy of the complaint, the question is raised as to whether the complainant was "fobbed off" or the original CAT scan misread. The answer to these questions is no and there was no misinterpretation of this scan (the scan was of the abdomen not the chest).

Dr Martin Watts

References:

The Health and Disability Commissioner

https://www.hdc.org.nz/media/cbfjbmy3/managing-patient-test-results-5nov08.pdf

"In the absence of any other arrangement being made, when results are received by a medical centre, the patient must be informed. This is especially important if the results raise a clinical concern and need follow-up."

The Medical Protection Society

https://www.medicalprotection.org/newzealand/casebook-may-2015/handling-test-results

"The primary responsibility for following up abnormal results rests with the clinician who ordered the tests. However, the HDC has an expectation that an abnormal result will be followed up by a treating doctor regardless of who ordered the test to avoid patients 'falling through the cracks'."

Best Practice, BPAC NZ

https://bpac.org.nz/bt/2014/august/testresults.aspx

"If you are responsible for conducting a clinical investigation you are also responsible for ensuring that the results are appropriately communicated to those in charge of conducting follow up, and for keeping the patient informed."'

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Dr Watts provided the following supplementary information:

'10th May 2023

Case; 20HDC01571

I have reviewed the letter and documents provided in your email of the 14th April 2023 and considered them alongside my original report of the 16th December 2021.

I still do not feel I/we have reached a conclusion as to where/why this report was lost.

Date	Event	Response	Comment
26/02/20	CT Abdomen performed and Chest X-ray taken	Abnormal findings not noted	Junior clinician and subtle findings
05/03/20	Report produced	Report sent to ED	Radiology completed their involvement
12/03/20	Report acknowledged by ED	No apparent action taken	No record of attempt to follow up

From the information provided I would note that: There were abnormal findings on the images taken on the 26th February, these were not initially noted by the ED staff at this time. These findings were seen and reported on the 5th March. The report was acknowledged on the 12th March and no action appeared to be taken at this time.

There were delays, but not critical delays, in producing the report and it being acknowledged in the ED. Radiology delays were relatively minor and they have then provided a report describing the findings and suggesting further imaging and follow up. It is at this point that the trail has been lost — by ED rather than by Radiology.

The new information does not change my previous conclusions. Particularly my statement in response to Question 4, paragraph 2:

"In the absence of a policy or guide, it would be appropriate for the ED to provide the HDC with some details of its system for viewing, acknowledging and acting on any results which arrive after the patient has left from their ED visit."

I do not think that the documents provided cover this or answer this important query. Pertinent questions would be:

Who (person or work role) views the reports when they are sent to ED? Is this person or role of appropriate seniority and are they given appropriate time and resources to complete this work? If there are significant abnormal findings is there an expectation that the patient/GP or other is informed and if so, by whom? If further investigation is suggested, such as imaging, who is responsible for ordering these further tests?

Dr Martin Watts'

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Appendix C: Medical centre's 'Managing Test Results and Clinical Correspondence'

'**Policy/Procedure Statement:**

Practices will have a system for the management of medical reports and test results that minimises the potential for errors and clarifies processes for staff and patients. The system will encompass monitoring, reviewing and acting on test results and medical reports.

Definitions

Medical Reports: Includes test results, clinical correspondence (including referrals for tests and procedures) and other clinical investigations, e.g. imaging reports

Procedure:

1. Incoming test results

All incoming medical reports are seen and actioned by the appropriate member of the practice team who requested these or a designated deputy.

[Medical centre] receives test results ***hard copy and electronic copies*** and this is the same for all ***laboratory tests and X-rays***.

If the result is received *electronically then it is directly entered into the provider inbox in the PMS system* and if it is received by *hard copy it is scanned in to the providers' inbox*. *If we receive an urgent result by hard copy it is given directly to the provider*.

If the person who ordered the test(s) is away, *the results are received and reviewed by the locum and action as appropriate*. *If no locum the Practice Nurse will review results and organise another GP to assess.*

The provider *indicates that they have read the report by the attention box being empty in the provider inbox — actioned/filed result.* They indicate the action that is required by the details that is entered into the comments box and maybe forwarded to Practice Nurse/ MCA to action.

If the results are normal or the report indicates no further intervention or action is required. *The patient is contacted if appropriate by either the provider or the practice nurse and then the results are filed in the patients' inbox by the Provider or Practice Nurse.*

If the test result is abnormal or if further intervention or referral is required *either the doctor contacts the patient directly to discuss results and comment noted in patient inbox or follow-up appointment if appropriate or the provider sends report/result to the practice nurses with comment and action required e.g. recall/notify patient. Once action completed nurse files result and comment noted in inbox. Our PMS system does allow us to have a recall system and for anyone placed on a recall a letter would be posted out.*

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If a patient is contacted over the telephone to discuss either a normal or abnormal result a record is kept of the conversation, noting the date and who advised the patient *in the patient inbox either in the comments box or in daily record if extensive notes.*

All patients registered to access the **ManageMyHealth** patient portal.

All normal results filed require a comment.

Significant abnormal results must not be filed until the patient has been notified directly, other abnormal results can be filed with a comment if the GP is satisfied that the patient can read and understand the comment on the ManageMyHealth portal.

Either the GP or the Practice Nurse can initiate the recall system (unless already programmed automatically as for Cx's). Recalls are actioned at the end of every month for the following months request or sooner if required. Cx's, mammogram and immunisation are recalled x 3 then they are recorded as a non-responder. Blood tests and miscellaneous are removed from recall and patients are accountable to respond. The PMS system is able to determine if the patient didn't attend for a recall appointment or appointment at which results were to be discussed.

If after 3 attempts to contact a patient by telephone fails a letter is posted. All action is documented in patient inbox and result filed or returned to GP for their attention.

Casual patients are dealt with the same as any patient.

The process for dealing with results ordered by a practitioner within the practice but for a patient seen in another setting (e.g. at Family Planning) — *the patient would be contacted to ensure appropriate and follow-up carried out if required.*

The process for dealing with tests and clarifying clinical responsibility when ordered by someone outside of the practice *would be the same as above — the patient would still be contacted and follow-up carried out if required.*

The process for dealing with tests ordered by someone outside of the practice and sent to our practice in error — patient not on your register — *the sender would be notified and or the laboratory advised.*

Grossly abnormal results

The laboratory telephones the practice and advises the Practice Nurse who passes this result directly to the GP. The result is then faxed for confirmation before being sent electronically.

— *If after hours the laboratory will contact the GP directly.*

— *If unable to contact GP the laboratory advises [the other clinic]*

Urgent Results

— *Are faxed directly to our practice and passed to the Practice Nurse to action immediately with appropriate GP.*

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— *If GP is away they are passed to Practice Nurse advises another GP for immediate follow-up.*

— *Results are also sent electronically.*

INR Results

— *Faxed directly to our practice and put at Practice Nurse/MCA station.*

— *INR result is recorded in INR folder; individual form for each patient*

— *The result is entered on the patient form and given to GP.*

— *GP completes INR dosage, retest time, and returned to Practice Nurse/MCA.*

— *Practice Nurse/MCA record in patient notes and contact patient with GP instructions.*

2. Patient notification

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

Our system for notification of results is explained *in our information leaflet given to all new patients and copies available at reception. Our practice policy — is that patients will be notified of an abnormal result and if action is required. They are advised of this and they can themselves enquire by phone or in person if they have not been notified but wish to know the result. They are also advised the period of time that the results usually take to return e.g. bloods 1 day, swabs 2 days, faeces 3 days approx.*

Written patient information on the practice policy re: notification of results is to be found *in the information leaflet.*

If the patient cannot be contacted by telephone *a letter is sent*.

3. Tracking test results and medical records

Our system for tracking test results, urgent referrals, and medical reports is as follows:

Medtech auto tracking facility is set up and used to issue reminders for all X-rays, laboratory investigations, & referrals where a request form is generated from Medtech. A reminder/ task is set to follow-up in two weeks. This tracking system alerts the provider to identify any results that remain outstanding.

When the result goes into the providers' inbox, the provider will review it and decide what follow up is required.

When a result has been received that is abnormal it will be noted and only removed once these results have been appropriately communicated to the patient.

4. General test management issues

Practices will refer to their privacy policy with respect to the management of test results.

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Locums should be made aware of your practice policy and procedures relating to test management — *Practice Nurse.*

New staff should be made aware of your practice policy and procedures relating to test management — *Practice Manager.*'

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Appendix D: Community HealthPathways — Neck lumps in adults

'**Investigations:**

- Fine needle aspiration (FNA) is not required for every neck lump if the clinical diagnosis is clear and the patient is at low risk of malignancy:
  - Do not request FNA for acute lymphadenopathy, lymph nodes smaller than 10 mm, stable long-term palpable lymph nodes, or diagnosis of stable lipoma.
  - Arrange FNA if lump is suspicious. If tuberculosis is a possibility, request acid-fast bacilli (AFB) and PCR on the FNA.
- If history and examination indicate a possible systemic cause, consider a chest X-ray and relevant blood tests.
- Ultrasound is not recommended as it is of limited diagnostic value and is not available via Community Referred Radiology.

Management

1. If a lump is likely to have an infective cause, treat with broad spectrum antibiotics. Recheck in 1 to 2 weeks for resolution, although complete disappearance may take a couple of months.'

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Appendix E: Electronic Result Acknowledgement: The Responsibilities of Senior Medical Officers and the Delegation of Authority to Resident Medical Officers and Others

'Purpose

The purpose of this Policy is to ensure the timely electronic acknowledgement of results for Waikato DHB patients. It outlines the responsibility that Senior Medical Officers (SMOs) have for acknowledgement and how authority may be delegated to Resident Medical Officers (RMOs and others).

Policy Statements

- All laboratory and radiology results are to be acknowledged electronically using the Clinical Workstation (CWS). Paper copies of laboratory and radiology results will not be generated.
- Electronic Acknowledgement is the electronic equivalent of signing a paper result and acknowledgement implies that any action required has been taken or is being organised.
- If results are not acknowledged there may be uncertainty as to whether any required action has been taken. For this reason no results should be left unacknowledged.
- All results should be acknowledged within 3 working days of being finalised. Any results not acknowledged within 10 days of being finalised will be considered non-compliant with acceptable clinical practice, and will be investigated by the team management.
- To facilitate timely acknowledgement, all doctors or other clinical staff with delegated authority should set up unacknowledged work lists.

3.2 Principles of Responsibility of SMOs for Electronic Acknowledgement

- SMOs are ultimately responsible for the management of patients under their care in hospital or seen in clinic under their name. Having responsibility includes taking responsibility for acknowledgement of results and any subsequent action required.
- While it is generally considered best practice that the requestor of a test should take responsibility for checking and acting on the result, in a hospital setting many tests will not be requested personally by the SMO.
- Test requestors must be very clear in their minds exactly who is to be responsible for acknowledging and taking action on every test ordered and must always ensure that the appropriate responsible SMO or team is identified when the test is ordered so the results appear on the correct unacknowledged work list.
- The responsibility for action of tests requested by RMOs and others, registered nurses (RN) acting under delegated authority, or performed during ED assessment

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normally passes onto the admitting SMO as long as the test is within their normal scope of practice.

- If another SMO (or delegate) consults on a patient and orders an investigation, the responsibility for acknowledging that investigation (and taking appropriate action) lies with the team who ordered it and not the admitting team.
- RMOs and others may acknowledge the majority of results but they do this under the delegated authority and it remains the responsibility of the SMO to ensure that results are acknowledged in a timely manner.
- It is the responsibility of SMOs to instruct RMOs and others (or delegates) of their expectations and indicate when the RMO (or delegate) can independently acknowledge results, what results the RMO (or delegate) should not acknowledge and what results the RMO (or delegate) should inform the SMO about before or after acknowledging.

1.1 Patients only seen by ED doctors

- If an Emergency department (ED) doctor orders an investigation and discharges the patient home, an ED SMO (or delegate) is responsible for acknowledging the result.
- The ED doctor should electronically acknowledge all results that are finalised prior to patient discharge and record in the discharge letter any results which are not yet available on discharge (especially microbiology and radiology) and which will require review.
- The patient's General Practice can only be asked to follow up on results if the name of the doctor is known. They **must** be explicitly requested to do so: this requires either a telephone discussion or an explicit request to be made in the discharge summary.
- If the result, when available, requires urgent or significant action, the General Practice must be telephoned to check that the action has been or will be taken.
- General Practices are unable to acknowledge hospital results electronically so an ED doctor still has to do this or the results will remain on the unacknowledged work list.
- Note results are not automatically copied to General Practices. See section 11 for details of how to ensure that a General Practice is sent a copy of the result.'

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