General Practitioner, Dr A

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 10HDC00454)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. On 16 November 2009, general practitioner Dr A examined a 29-year-old woman, Ms B. She reported that she had been experiencing right-sided sciatic pain and tingling in her right foot for four days. Dr A considered that Ms B was suffering from a disc prolapse and consulted orthopaedic surgeon Dr F at the public hospital, who agreed with this diagnosis and approved Dr A ordering a CT scan for Ms B. Dr A referred Ms B to the orthopaedic clinic and provided her with a prescription for pain relief and anti-inflammatories.

2. On 20 November, Ms B returned to see Dr A because her pain was ongoing and she had developed urinary incontinence. Dr A considered this new development a "red flag" and tried unsuccessfully to contact the on-call orthopaedic surgeon, Dr C. Dr A contacted the hospital radiologist to bring forward Ms B's CT scan appointment and left Dr C a message about his patient. At 2.52pm, Dr A faxed a referral for Ms B to Dr C at his private clinic. Dr A instructed Ms B to go to the hospital emergency department [ED] over the weekend if she did not hear from Dr C or if her symptoms worsened.

3. At 7pm, Dr C picked up Dr A's message, which did not include contact details for Ms B. Dr C went to the ED and the wards to look for a patient with the symptoms Dr A described. No patient of that description presented to the ED over the weekend.

4. At 9.15am on 23 November, Ms B presented to the hospital radiology for her CT scan. Meanwhile, Dr A's referral arrived in the mail at Dr C's private clinic. Enquiries were made and Ms B was contacted and asked to present to Dr C's clinic. Dr C operated on Ms B later that day to decompress the L5/S1 spinal disc. Ms B has a permanent disability as a consequence of her disc prolapse.

Decision summary

5. Dr A had a duty to ensure that Ms B received a specialist review on 20 November. Dr A did not fulfil this duty. Dr A did not follow up his telephone message and fax to the specialist, and did not impress upon Ms B the need for a timely review. By not ensuring that Ms B was reviewed by a specialist in a timely manner, Dr A failed to minimise potential harm to Ms B. Dr A also failed to ensure co-operation among providers to ensure quality and continuity of services. Therefore, Dr A was found to have breached Rights 4(4)[1] and 4(5)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

6. The medical centre was not found to be vicariously or directly liable for Dr A's breach of the Code.

Adverse comment

7. Dr C acknowledged that he had been advised about a patient with a spinal problem who had developed urinary problems. Although Dr C looked for the patient in the hospital ED and on the ward, he should have made more attempts to track down Ms B. Dr C's failure to take a

[1] Right 4(4) of the Code states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."
[2] Right 4(5) of the Code states that every consumer has the right to co-operation among providers to ensure quality and continuity of services.

more proactive approach to track down Dr A's patient was an important link in the chain of events that led to Ms B not receiving the timely specialist care that she needed.

8. At the time of these events, the DHB did not have a written protocol for primary care referrals to the ED, and acknowledged that there was no consistent approach from senior medical staff working in specialties with respect to the processing of acute referrals from GPs. Confusion about procedures for GPs to refer patients to hospital specialist services has the potential to affect patient care. Primary care centres and district health boards need to work together to develop clear, unambiguous systems for referring patients between primary and secondary services in their respective areas.

9. In March 2012, the DHB updated its processes for GP referrals to ED. A process document, "Procedure for Acute Admission — GP Referral" was circulated to hospital staff, and displayed in ED. There is now a direct Primary Care Referral Line, which enables primary care providers to speak directly with a senior ED doctor. A new fax number has been introduced for all outpatient departments to enhance primary/secondary care communication. A new ED specialist has been employed, which has improved the number of patients being assessed.

10. The medical centre has made a number of systems changes, ie, improving its method of faxing referrals to the hospital, and organising monthly staff meetings to discuss cases and systems issues.

Investigation process

11. On 16 April 2010, the Commissioner received a complaint from Ms B about the services provided by general practitioner Dr A. The following issue was identified for investigation:

    - *Whether Dr A provided Ms B with services of an appropriate standard on 20 November 2009.*

12. An investigation was commenced on 15 September 2010.

13. The parties directly involved in the investigation were:

Ms B	Consumer
Dr A	Provider/general practitioner
Dr C	Orthopaedic surgeon
The medical centre	
The district health board	

14. Information was reviewed from:

Dr A
Dr C
Ms D, Dr C's private clinic secretary
Ms E, the medical centre's practice manager

The medical centre
The district health board

Also mentioned in this report:

Dr F	Orthopaedic surgeon
Dr G	General practitioner

15. Independent clinical advice was obtained from general practitioner Dr David Maplesden (**Appendix A**). Independent orthopaedic advice was obtained from consultant orthopaedic surgeon Dr Garnet Tregonning (**Appendix B**).

Information gathered during investigation

16 November 2009

16. On Monday 16 November 2009, Ms B (then aged 29 years) presented to medical practitioner Dr A at the medical centre. She reported a history of four days of worsening right-sided sciatic pain following a slip in the shower. She also reported numbness and tingling around her right foot.

17. Dr A examined Ms B and found that she had a loss of her right ankle jerk. She also had reduced straight leg raise of her right leg, with pain occurring at 20 degrees of lift. He found no defect on the left side. Dr A considered that Ms B had "a near 'full house' of symptoms for possible disc prolapse". He recorded in Ms B's clinical records:

> "3wk ago slipped backwards & braced herself with arms, acute R [right] leg pain, initially not so bad, kept working but last [4 days], constant day & night, sciatic distribution, numbness & tingling around foot, weakness & loss R AJ [right ankle joint], also SLR [straight leg raise] 20deg on R … L [left] leg ok."

18. Dr A telephoned orthopaedic surgeon Dr F[3] at the public hospital (the hospital) to discuss Ms B's symptoms and management.

Dr F

19. Dr F advised HDC that although Dr A advised him that he would like Ms B to be seen by an orthopaedic surgeon in the Outpatient Clinic "before too long", Dr A did not ask for Ms B to be seen as an emergency. Dr F told Dr A that if he wanted to refer Ms B as an urgent referral to the hospital's orthopaedic outpatient clinic, the referral should be sent directly to him and he would make seeing Ms B a priority when the referral came to his attention. Dr A asked Dr F whether a CT scan would be justified at that stage. Dr F told Dr A that a CT scan would be a "useful" investigation to have and that it would save time if the scan could be arranged before Ms B presented at the outpatient clinic.

[3] The DHB advised that Dr F was working at the hospital as a locum in November 2009.

Referrals

20. Dr A recorded in the computerised notes for his consultation with Ms B on 16 November 2009, "d/w Ortho … [Dr F] for CT & ref [Dr C] [referral to orthopaedic surgeon Dr C]". Dr A advised Ms B to take a week off work and prescribed analgesic and anti-inflammatory medication. As Dr F had authorised a CT scan of Ms B's lumbar spine, Dr A faxed the CT request to radiology, and a copy of his consultation to the orthopaedic outpatient clinic.

17 November

21. A nurse's comment in Ms B's medical centre clinical records, dated 17 November, notes, "[Telephone] In excruciating pain [and] burning with back pain, does not feel that [prescribed] analgesia is cutting the mustard. [Discuss with Dr A]."

20 November

22. On Friday 20 November, Ms B returned to see Dr A as her symptoms had increased, and she had some urinary incontinence. Dr A was fully booked and initially Ms B was seen by another GP, Dr G.

23. Ms B stated that she told Dr G of her earlier visit to see Dr A regarding her back problem and that she was still waiting for an appointment for a CT scan. Ms B told Dr G that she had lost control of her bladder "since the day before". Dr G asked her if her bowels had moved, and when Ms B replied that they had not but this was not unusual, Dr G told her that she should see Dr A, as he was her usual doctor and knew her history.

24. Ms B recalls that when she was "finally" able to see Dr A he seemed very pushed for time and told her that he needed to pick up his children.

25. Dr A advised that he saw Ms B in the mid to late afternoon, and immediately recognised the new development of loss of bladder control as a "red flag" and an indication that her situation was worsening. Dr A advised HDC that he spoke to the hospital telephonist to ask who was on call for the orthopaedic team, and was told that it was Dr C. Dr A stated, "I called through twice [to Dr C] because I wanted to speak to him to discuss the case, but with no answer."

26. As Ms B had not had the CT scan, Dr A contacted the hospital radiology department to try to expedite the scan. He spoke to the senior radiographer, who advised him that Ms B had a booking for the following week, but that there was an appointment available at 9.15am on Monday 23 November owing to a cancellation. Dr A asked that Ms B be booked in for this appointment. Dr A then telephoned Dr C again and left a message on his telephone regarding Ms B.

Telephone message

27. There is discrepancy about what information Dr A actually left for Dr C about Ms B in his telephone message.

28. Dr A advised HDC that, after talking to the radiologist, he tried again to contact Dr C. When he was unsuccessful on that occasion, he left a message on Dr C's mobile phone, during which he says he identified himself and Ms B, described her symptoms, which included the recent development of urinary incontinence, and stated that her CT scan had been brought forward to Monday 23 November. Dr A stated that he also advised Dr C of Ms B's contact details (which he said he would also fax through) in case Dr C wanted to arrange for her to be seen in the ED.

29. Ms B's recollection of Dr A's message to Dr C was:

> "I have a 29 year old female presenting with back and hip pain, with shooting pain down her right leg, I believe that she has sciatic nerve damage. She is otherwise a fit and healthy person, however today she has presented to me with having problems with not been able to control her bladder and the pain is more severe. She is unable to sit or stand for even short periods as the pain is not under control. She is on a high dose of codeine but is not getting any relief. She has managed to get a C.T. scan on Monday morning. If you could please get back to me that would be great. Thanks [Dr A]."

30. Dr C stated that he was in theatre when Dr A telephoned. Dr C recalls that he received Dr A's message after the operation concluded, at about 5pm. Dr C stated that Dr A's message explained that he was concerned about one of his patients with a "three week history of back pain, lower limb weakness and some objective neurology". Dr A stated that he had discussed the case with orthopaedic surgeon Dr F a "few days before", and a decision had been made to refer her electively for consultation and scanning of her lumbar spine. Dr A indicated that the patient had deteriorated in the few days subsequent to his discussion with Dr F, that she had urinary symptoms, and that he was referring the patient more urgently.

31. Dr C stated:

> "No details were left regarding the name of the patient or any contact details, nor were any details left with regard to contacting the general practitioner. My assumption therefore was that the patient was being referred to the Emergency Department at [the] Hospital for my assessment which would be standard practice."

32. Dr A advised that his contact details are available at the hospital if Dr C had wanted to get hold of him for more information. Dr A stated that Dr C should have contacted him when Ms B did not present at the ED.

33. The telephone message Dr A left was not retained.

Fax referral and advice to Ms B

34. Dr A stated that after leaving the message with Dr C:

> "I then wrote and faxed a copy of my consult & management to the orthopaedic department. My intention in doing these things was to advise them that I was passing responsibility on to them for her care given her presentation. I then told [Ms B] to seek further medical attention if her symptoms got worse over the weekend."

35. Dr A faxed the referral for Ms B to Dr C intending that he should receive it at his private clinic. The referral, a computerised print-out of Dr A's 16 November 2009 assessment of Ms B, stated:

> "[Dr C] Private Fax […]
>
> Returned ++ pain
> Now loss of urinary control
> No saddle anaesthesia
> Rung CT & ortho again

Ring "[Dr C] — left message
9.15am CT Mon booked."

36. Dr A annotated the bottom of the print-out referral with Ms B's ACC claim number, and the details of his 20 November assessment. Dr A also stamped the referral with his surgery stamp, writing "from" above the stamp. (A copy of the referral is **attached** as **Appendix C**.)

37. Dr A entered his assessment in the computer as:

"Severe lumbar pain into R leg, sciatic, still nil AJ relex.
Lost of control of urine, but no saddle anaesthesia/numbness
Rung and left message with [Dr C]
Rung CT scan
Re Faxed letter/copy consult."

38. Ms B stated:

"… once he had left the message on "[Dr C's] phone [Dr A] told me to take more of the codeine, get some rest and not to drink too much water until my C.T. scan on the Monday after the weekend. He left it at that."

39. Ms B stated: "I went home and had the worst weekend of my life with the pain and the worry that I might over dose on the pain killers as they weren't doing anything."

Dr C

40. Dr C stated that after receiving Dr A's telephone message:

"I continued my afternoon operating list, and, at the conclusion of that, which may well have been around 7pm, I went through to the Emergency Department and the ward at [the] Hospital to determine whether a patient with this problem had been seen. I discussed the case with the attending Medical Officer who had not seen a patient of this nature come through the department during his shift. I left instructions therefore to contact me as soon as such a patient attended the hospital. No such response occurred over the weekend."

41. Ms B did not present to ED and was not seen by a specialist over the weekend.

Monday 23 November

42. There are some inconsistencies between the various recollections about the circumstances of Ms B being seen by Dr C on Monday 23 November 2009.

43. Dr C stated that Dr A's referral did not arrive at either his private clinic, or the hospital's orthopaedic department. He recalled that Ms B arrived at his private clinic on the morning of 23 November. She said that three days earlier her GP had told her to have a CT scan on Monday.

44. Dr C's private clinic secretary, Ms D, recalls that the referral from Dr A arrived in the mail on Monday morning. She said that Dr C had been expecting a patient with this problem over the weekend, and there was a "ring around" on Monday morning to try to locate Ms B. Ms D contacted radiology and found that Ms B had just left. She then contacted Ms B (whose home

and mobile phone numbers were on the top of the referral) and asked her to come into the clinic.

45. Ms B corroborated Ms D's recollection. Ms B advised HDC that she was contacted by Dr C's secretary while she was on her way home from having her CT scan. She was asked to go straight back to the hospital as Dr C wanted to see her. Ms B said that she saw Dr C within 30 minutes of arriving at his clinic. Ms B recalls that Dr C told her that he had been expecting her to come into the ED on either Friday or over the weekend. He told her that her situation was a medical emergency and she had 48 hours after the onset of the bladder incontinence to have surgery to have the best chance of recovery. He said that he had been trying to contact her, and that she needed to have surgery that day. Dr C told her to go home and get a bag packed for admission to the hospital.

Subsequent events

46. Dr C booked a theatre and performed an urgent L5/S1 discectomy on Ms B that day.

47. Dr C then wrote to Dr A stating:

> "Thank you for referring urgently this young lady.
>
> As you are aware you left a message on my phone on Friday evening but unfortunately I could not track [her] down. She did not come to the hospital at that stage nor over the weekend and I was on call and would have been notified if she had. …
>
> I feel most uncomfortable, as I am sure you did on Friday, about her status with urinary incontinence and have admitted her urgently.
>
> The CT organised prior to the appointment with me shows a central disc prolapse of L5/S1 with almost certainly a moderate degree, at least, of cauda equina compression."

48. Dr C said that Ms B improved to some extent after the initial surgery. However, when orthopaedic consultant Dr F reviewed her at the end of December 2009, he was concerned about her ongoing symptoms and clinical signs.

49. Ms B has had two subsequent surgeries, but has significant ongoing neurological symptoms indicative of cauda equina syndrome.[4] She has been referred […] for rehabilitation. Dr C stated: "She undoubtedly will have permanent disability as a consequence of her disc prolapse."

Additional information

Dr A

50. Dr A stated that after these events he had telephone conversations with an orthopaedic surgeon and the DHB's Chief Medical Officer to discuss the difficulties he encountered contacting the orthopaedic team on Friday 20 November. Dr A advised HDC that after the new ED opened in 2009 the GPs were told to contact medical specialists directly before sending patients to the ED. They were advised not to refer via the house surgeon or send the

[4] A serious neurological condition in which there is acute loss of function of the lumbar plexus, neurological elements (nerve roots) and the spinal canal below the termination of the spinal cord.

patient directly to the ED. Dr A said: "I thought I was following the correct protocol [on 20 November 2009]."

51. Dr A advised HDC that he had discussed with his the medical centre colleagues the difficulties being experienced by GPs when referring patients to the ED, and that he intends to change the manner in which he accesses specialist service in future.

The medical centre

52. The medical centre has not provided HDC with any policy or procedure regarding the referral of patients (either acute or non-acute) to the hospital. The medical centre's Practice Manager, Ms E, advised HDC that the system in place at the clinic for referring non-acute patients to the hospital is that all referral letters are sent to the hospital via internal mail. The letters are collected from the clinic twice a day. She said that the clinic had no written instruction from the hospital about changes to the system for acute referrals, and believes that any information about referral changes was disseminated verbally amongst the practice clinicians.

The DHB

53. The DHB's Chief Medical Advisor advised HDC that "[i]t appears that there is no consistent approach from senior medical staff working in specialties other than emergency medicine with respect to the processing of acute GP referrals for specialist assessment in the ED". The DHB later advised HDC that in 2009 the process for patients to be referred from primary care to a medical specialist was for the GP to call the relevant specialist to request an urgent assessment and to arrange for the patient to present to the ED to be seen, unless instructed otherwise by the specialist. ED staff then notified the specialist or his/her house surgeon when the patient arrived in the department and requested that he or she attend to conduct the medical assessment. GPs wanting specialist review of a patient also had the option of referring patients by telephone or sending the patient to the ED for a review by ED staff.

54. The Chief Medical Advisor advised HDC that in 2009 the DHB did not have a written protocol for primary care referrals to the hospital ED. There was an expectation that GPs would telephone the senior medical staff based in the ED (or a junior medical officer if the senior was unavailable) prior to sending a patient into the ED for assessment. The DHB advised HDC that the process of GP referrals to ED (as opposed to referring for specialist review) was updated in March 2012. A process document, "Procedure for Acute Admission — GP Referral" has been circulated to hospital staff, and a laminated copy of this document is displayed in ED.

55. Additionally, a protocol for the processing of "Primary Care Referrals to [the] ED on phone" was drafted. The protocol attempts to streamline referrals to ED through the establishment of a dedicated phone line for doctor-to-doctor referrals. The new line is intended to be answered by, or directed to, the ED Senior Medical Officer between 8am and 11.30pm. The protocol states that, in all cases, the ED expects a referral letter to be clearly addressed to the accepting doctor, which includes a summary of the acute problem, past history, current medications and allergies. The DHB advised HDC in March 2012 that this protocol is to be implemented as a priority once a dedicated "red telephone" (to be carried by the senior medical officer on duty) is available.

56. The DHB also advised HDC in March 2012 that the ED Charge Nurse Manager will liaise directly with the Primary Health Organisation, for broad distribution of this information.

Dr A

57. Dr A stated:

> "With the benefit of hindsight, I have reflected on why I didn't just send [Ms B] to ED with a note or try to contact another specialist. Sending her direct to ED would probably have been the best way for [Ms B] to receive specialist assessment on the Friday. I did with all sincerity however, believe that [Dr C] would get my message (which it appears he did) and would contact [Ms B] or myself if he thought more urgent action was necessary. However, I accept that it was my responsibility to ensure that [Dr C] got my message and it was not good enough to just leave a message. I would not, faced with the same situation, do this again.
>
> At the time I was also reassured by the fact that I had already contacted the orthopaedic department and spoken to a specialist [Dr F] and was partially reassured by the fact that her scan had been brought forward to the Monday morning. … However, again I totally accept that I should have sent her to ED in the absence of being able to speak to a specialist.
>
> I have discussed [Ms B's] case with my colleagues as individuals and at our last peer review group meeting. My peers acknowledged the difficulty of contacting specialists and delays in accessing acute services at times and I intend following up this aspect of [Ms B's] case to ensure that GPs in our practice are clear about communication between primary and secondary care in [the town]."

58. HDC has not been advised about any further action that Dr A may have taken regarding his concerns about the difficulty GPs have contacting specialists and delays in accessing acute services at the hospital.

Responses to provisional opinion

59. The parties were offered an opportunity to respond to my provisional opinion. The following responses were received.

Dr A

60. In response to the provisional opinion, Dr A stated: "I would like to apologise sincerely for not having participated in the investigation as I should have, and responded as requested [sic]."

61. Dr A acknowledged that there was discrepancy in the information provided about his telephone message to Dr C. He commented that Dr C has provided conflicting information to HDC — on one hand in his follow-up letter, thanking Dr A for "referring urgently this young lady", he acknowledged that Dr A had left a message on Friday evening, but "unfortunately I could not track [Ms B] down". Dr A said that Dr C's later statement to HDC does not mention that he had been trying to contact Ms B prior to her appearing at his clinic on Monday morning, but that he was waiting to be advised when Ms B attended the hospital over the weekend that he was on call. Dr A stated:

> "In my view [Ms B's] recollection and [Dr C's] letter immediately after her surgery are consistent with my recollection that I did leave her contact details and that [Dr C] did try to contact her knowing that the situation was serious, otherwise why would he have said he had tried to contact her?"

62. Dr A said he is certain that he clearly said in his telephone message for Dr C that Ms B was not going to the ED, and that Dr C was to contact her. Dr A said: "There does not seem to be any dispute that Dr C did get the message on Friday night. I did leave a name and I did leave clinical details for her."

63. Dr A said that when he saw Ms B on Friday 20 November, she had only intermittent bladder incontinence. He said that at this time he did not know that this was a chronic condition for her — that she had been admitted previously with this condition, but no cause had been found. Dr A said: "Obviously, if cauda equina had been evident I would have sent her straight up, but she had no obvious signs."

64. Dr A stated:

> "My position was that having received the message that I was referring a patient to him with very serious symptoms and given [Dr C's] view that there was a limited window of opportunity to attend to [Ms B], if [Dr C] had any concerns regarding the message, or the information left in the message (or lack of information if he considered that to be the case), or if he could not get hold of [Ms B], as he said, then I would have thought it not unreasonable for [Dr C] to try to call me. …
>
> I have accepted responsibility for not following up to ensure that [Dr C] had got the message or the fax at his rooms over the weekend when he was on call. I have said that in retrospect, ringing later on in the evening to ensure he had the message would have been the next step for me to check up on [Dr C's] action or lack of it and that this could possibly have achieved a better outcome for [Ms B]. I am sincerely regretful that in the circumstances I did not do that."

65. Dr A stated that the medical centre has made changes since these events, which include amending its Fax Policy. The medical centre achieved Cornerstone Accreditation Process in 2011, and is about to undergo its yearly review. Dr A arranges and mediates a monthly internal peer review meeting, and one of the subjects for discussion at an upcoming meeting is the outcome of this complaint and the HDC report. The medical centre staff meet regularly to discuss cases and system issues.

66. There have been changes in the interaction between the primary and secondary care services. Dr A stated that a new ED specialist has been employed at the hospital, and the philosophy of ED seeing all patients that attend rather than turning a number away has changed. This has improved the ability of sending patients through to the hospital. Since March 2012, GPs have had direct access to the "Primary Care Referral Line". A senior Medical Officer Special Scale in ED carries the phone around, and GPs can ring directly to it to speak to a doctor. Dr A stated that he has used this system and found that it has improved "the flow" of decision-making hugely. On 13 January 2012, in order to minimise the confusion around phone/fax numbers and assist with hospital and primary care communication, a combined fax number for all public outpatient departments at the hospital was established. Some on-call specialists

are now putting on their answerphone messages: "Please send patient to ED or ring ED if I am not contactable."

67. Dr A stated that as a result of these events he has made a number of changes to his practice. He has discussed these events with his peer group, and is "going to make sure I write more full notes from now on". Dr A stated that he leaves fewer phone messages now and, if he does leave a message, he follows up serious or urgent cases to check whether the message has been received. He said that he also follows up any acute referral faxes, such as ED and specialist referrals and requests for X-ray or ultrasound, with a phone call, and checks that the fax number is correct. Dr A is reviewing the medical centres process for faxing consultation notes in Med Tech, which does not always generate the full patient details, and is arranging IT input to improve the system.

Dr C

68. In response to the provisional opinion, Dr C commented that the focus of the Commissioner's report — Ms B's referral to the hospital over the weekend of 20 to 22 November 2010 — overshadowed her three-week history of deteriorating symptoms and increasing lower limb neurology in her right leg. He considered that this focus is unreasonable, as he believes Ms B's predicament was irreversible by 20 to 22 November 2010. He also noted that Ms B did not choose to see another physician while she was waiting for an appointment, or present to the hospital.

69. Dr C said that the severe pain Ms B reported on 16 November and through the week to 20 November indicated an "ischaemic nerve root in real trouble". Dr C noted that orthopaedic surgeon Dr F offered Ms B a consultation at any stage from 16 November when Dr A discussed Ms B's condition with him. Dr C said:

> "The correct pathway in such circumstances, in my opinion, would have been to take up [Dr F's] original offer and have the patient seen and assessed properly by a senior clinician, not as did eventually occur focussing on a CT scan which would have only been necessary to prove the diagnosis. An alternative pathway at the end of the week would have been immediate referral via the emergency department to the hospital."

The DHB

70. The DHB did not respond to the provisional opinion.

Opinion: Dr A

Assessment and diagnosis — No Breach

71. When Ms B consulted Dr A on 16 November 2009 reporting a four-day history of right-sided sciatic pain and tingling in her right foot, he examined her and considered that she had a spinal disc prolapse. He discussed her problems with Dr F, an orthopaedic surgeon at the hospital, organised for her to have a CT scan to confirm the diagnosis, and prescribed medication to treat the symptoms.

72. On 20 November, Dr A saw Ms B again when she reported ongoing pain and the new development of intermittent urinary incontinence. He realised that she needed an urgent

specialist assessment and contacted the radiology department to bring forward her CT scan appointment. Dr A attempted to contact the on-call orthopaedic surgeon, Dr C, directly by telephone. When he was unable to reach Dr C, Dr A left Dr C a message describing the details of Ms B's situation, and then faxed a referral for her to what Dr A understood to be Dr C's private clinic's fax number. Dr A advised Ms B to seek further medical attention if her symptoms got worse over the weekend.

73. I am advised that there are few surgical emergencies in the treatment of back pain, but cauda equina syndrome is one that should be recognised by all GPs. The New Zealand Guidelines Group's "New Zealand Low Back Pain Guidelines 2003" states: "Cauda Equina Syndrome is a medical emergency and requires urgent hospital referral. … All patients with symptoms or signs of Cauda Equina Syndrome should be referred urgently to hospital for orthopaedic or neurological assessment." The symptoms include urinary retention, faecal incontinence, saddle numbness, and neurological symptoms such as gait abnormalities. I am also advised that it is common knowledge among medical practitioners that cauda equina syndrome is a serious complication of back pain, and one that should be recognised by all general practitioners.

74. HDC's clinical advisor, Dr Dave Maplesden, advised that Ms B's presentation was suspicious for cauda equina syndrome. Dr A also recognised this, and Ms B's need for an urgent specialist review. In my view, Dr A's clinical assessment and diagnosis of Ms B was competent, and his clinical documentation of his two consultations with her was consistent with expected standards.

Referral — Breach

75. Dr A appropriately recognised that Ms B's condition had worsened on 20 November and that she required a more urgent specialist review. Given the seriousness of Ms B's presenting condition, it is my view that Dr A had a duty to take all reasonable steps to ensure that Ms B received a specialist review on 20 November. For the reasons set out below, it is my opinion that Dr A did not adequately fulfil this duty.

76. When Dr A was unsuccessful in contacting Dr C he left a message on Dr C's mobile giving details about Ms B's symptoms and the actions taken. He then informed Ms B to seek further medical attention if her symptoms got worse over the weekend. While Dr A believes that he left his and Ms B's contact details for Dr C, neither Dr C's or Ms B's recollection of the telephone message confirms this. I accept, however, that Dr A did identify himself in the telephone message and that Dr C would have been able to obtain Dr A's contact details.

77. Dr A believes that when Ms B did not present at the ED, Dr C should have contacted him.

78. Dr A's duty to take all reasonable steps to ensure Ms B received a specialist review on 20 November required him to do more than leave a telephone message with the specialist and fax a referral to the specialist's private clinic. It was unwise for Dr A to assume that those actions alone would result in Ms B receiving the timely specialist care that she needed. Contrary to Dr A's submission, his responsibility for Ms B did not pass to the hospital orthopaedic department when he left a message with the specialist advising him of her condition and the need for specialist care. Dr A's duty was ongoing and, in this case, the duty required him to take a more proactive approach to Ms B's management. This requirement is

supported by Medical Council of New Zealand guidelines (see below), and previous HDC opinions.

79. The Medical Council of New Zealand's *Good Medical Practice: A Guide for Doctors* (2009) (the Guidelines) provides that when a patient is referred, the referring doctor must "provide all relevant information about the patient's history and present condition". The guidelines further provide that, "when the transfer is for acute care, this information should be provided in a face-to-face or telephone discussion with the admitting doctor".[5] Furthermore, the guidelines provide:

> "When a patient is being transferred between a doctor and another health care practitioner, he or she must remain under the care of one of the two at all times. Formal handover is essential. The higher the degree of activity, the more important it is to ensure appropriate communication at the point of transfer. The chain of responsibility must be clear throughout the transfer."[6]

80. Ms B required an urgent acute referral for specialist care, and Dr A recognised this. Seamless patient care requires that clinicians act to ensure their concerns are being appropriately actioned. Dr A did not take sufficient action to ensure his concerns about Ms B's condition were being appropriately addressed. He should have taken further steps to ensure he discussed Ms B's case and the referral directly with Dr C, and that there was a clear passing of responsibility for her care to Dr C.

81. As previously stated by this Office:[7]

> "GPs have a key role to play in following up referrals to check that they are actioned promptly. For most patients, their GP is the health care provider who is best placed to keep an overview of their care. … An aspect of this duty is actively following up a referral for a patient who is still awaiting a further specialist assessment. … I consider that the GP retains a residual responsibility to monitor the progress of the patient through the system."

82. In another opinion,[8] where a GP assumed that putting a letter in the mail fulfilled her professional responsibility to a potentially life-threatening situation, this Office stated that GPs who refer patients to a specialist also need to take reasonable steps to follow up the referral, especially if the patient's need for specialist assessment becomes more urgent. In the District Court, on an appeal against an ACC Review Board decision to quash the ACC finding of Medical Error against a general practitioner, Judge Beattie stated:

> "In all the circumstances I find that the acts and omissions of [the general practitioner] … when she failed to identify the degree of urgency that was required to have Mrs P seen by the appropriate specialists and therefore given over to the appropriate treatment without

[5] See paragraphs 51 and 52 of the Medical Council of New Zealand's *Good Medical Practice: A Guide for Doctors* (2009).
[6] See above, paragraph 44.
[7] Opinion 07HDC20199.
[8] Opinion 01HDC04864.

delay, was inexcusable and constitutes a failing below the standard of care expected in the circumstances."[9]

83. Judge Beattie held that in the above case "a degree of aggression" was called for in following up the referral. Although in this case Dr A did correctly identify the degree of urgency required to have Ms B assessed by a specialist, in my view he did not exercise the degree of aggression required in response to that need. Although Ms B's condition was not life threatening, it was a medical emergency, and Dr A was well aware that there was a risk she might develop a significant neurological impairment if her condition was not treated. There were other steps that Dr A could reasonably have taken to ensure that his referral was actioned promptly. For example, Dr A could have instructed Ms B to present to the ED if she did not hear from Dr C by the end of the day, and he could have contacted Dr C and/or Ms B later that day to confirm that the referral had been received and actioned. This was a potential orthopaedic emergency, and Dr A's actions were not adequate.

84. I have taken into account Dr A's submission to the provisional opinion, that given the serious concerns he outlined in his telephone message to Dr C, and that there was a limited window of opportunity to attend to Ms B, it would not have been unreasonable for Dr C to contact him when Ms B did not present to the hospital. I agree and have commented in a following section on Dr C's omission to follow up Dr A's telephone message. However, I remain of the view that Dr A's passive approach to Ms B's management and referral meant that Ms B fell through the cracks, and did not receive the seamless and timely service that she was entitled to.

Summary

85. Dr A had a duty to take all reasonable steps to ensure that Ms B received a specialist review on 20 November. He did not take all such steps, and therefore exposed Ms B to an unnecessary degree of risk. In my opinion, by not ensuring that Ms B was reviewed by a specialist in a timely manner, Dr A failed to minimise potential harm to Ms B, and breached Right 4(4) of the Code. Dr A also failed to ensure co-operation among providers to ensure quality and continuity of services to Ms B and, accordingly, breached Right 4(5) of the Code.

Opinion: No Breach — The medical centre

Vicarious liability

86. Under section 72(3) of the Health and Disability Commissioner Act 1994, employing authorities are responsible for ensuring that their agents comply with the Code, and may be vicariously liable for an agent's failure to do so. Under section 72(5) it is a defence if an employing authority provides evidence that it took such steps as were reasonably practicable to prevent the breach of the Code.[10]

[9] *P v ACC*, District Court Palmerston North, No. 129/04, 27 April 2004.

[10] While the defence set out in section 72(5) refers to "employees", it is generally considered as also being available in respect of agents (see: *Totalisator Agency Board v Gruschow* [1998] NZAR 528).

87. Dr A is one of the five medical practitioners working in partnership at the medical centre. He has been practising as a full-time GP for 15 years and has been working at the medical centre for five years.

88. The medical centre did not have any policies and procedures in place to guide staff on the system for referring acute patients to hospital for assessment. However, it is my view that Dr A's failure to appropriately refer Ms B to specialist care was an individual error. Dr A, as Ms B's GP, had a clear duty to adequately action his referral, and he failed to do so. The standard of care required of an individual practitioner in referring patients is clearly set out in the Medical Council's document *Good Medical Practice: A Guide for Doctors*. This standard of care applied irrespective of any policies or procedures that were or were not in place at the medical centre. Accordingly, I find that the medical centre is not vicariously liable for Dr A's breach of the Code. However, I do have concerns about the lack of a formalised process for the referral of patients between the DHB and primary care centres at that time, and this is discussed below in the section "additional comment".

Adverse comment — Dr A/The medical centre

89. I am concerned about the lack of co-operation that Dr A and the medical centre have displayed during this investigation.

90. The medical centre Practice Manager Ms E was advised on 14 May 2010 of Ms B's complaint about the care Dr A provided to her. On 3 June 2010, Ms E advised HDC that Dr A was "well aware" of the complaint and working on his response. HDC received Dr A's response on 23 June. On 15 September, after a review of the information gathered and the clinical review provided, it was decided that formal investigation of Ms B's complaint was warranted, and Dr A and the medical centre were advised and asked to respond to specific issues relating to the process at the clinic and follow-up of these matters.

91. Since that time, Dr A and the medical centre have been contacted by telephone, email and letter a total of 13 times in an attempt to obtain further information, including actions taken in relation to Dr A's statement that GPs in the region experience difficulties in contacting specialist and acute services for their patients; clarification of the procedures that the practice has relating to hospital referrals; and follow-up of complaints and significant issues.

92. Although Dr A has now responded and expressed his sorrow for the distress Ms B has suffered, I find his lack of co-operation, which has severely hindered the investigation and consequently resolution for Ms B, unacceptable. The Medical Council of New Zealand's publication *Good Medical Practice: A Guide for Doctors* (2009) sets out professional standards expected of doctors in respect of co-operating in formal proceedings:

> "You must cooperate fully with any formal inquiry into the treatment of a patient and with any complaints procedure that applies to your work."

I acknowledge Dr A's subsequent apology for "not having participated in the investigation as [he] should have".

Adverse comment — Dr C

93. Dr C was the orthopaedic surgeon on call for the weekend of 21-22 November 2009. Between operating on patients on the afternoon of Friday 20 November 2009, he picked up Dr A's message about a patient with a deteriorating spinal condition and urinary incontinence. Dr C advised that he went to the ED and the ward to look for the patient referred to in Dr A's telephone message and, when he found that the patient had not presented, left instructions that he was to be notified if she should arrive.

94. Dr C acknowledged that he had been advised about a patient with a spinal problem who had developed urinary problems, and that he initially made an attempt to find this patient, but did nothing else to follow up Dr A's message. My independent orthopaedic surgical advisor, Dr Tregonning, advised that Dr C should have made attempts to track down Ms B on Friday evening, and certainly over the weekend. He said that this omission would be viewed by peers as a mild departure from the expected standard.

95. I agree with Dr Tregonning that Dr C also had a responsibility to Ms B in this case. The responsibility for managing the referral of patients between primary and secondary care does not fall solely on the shoulders of the primary care physician. While there is a clear division of responsibility in the management of patients following specialist referral, it is essential that general practitioners and specialists work together to ensure quality and continuity of care for patients. As previously stated by this Office:

> "Handling care between primary and secondary care is a crucial step in ensuring safe/quality care. It is also a vulnerable step which, if not carefully managed, is an area that can cause misunderstanding and sub-standard care."[11]

96. In recognising the seriousness of the symptoms described in Dr A's telephone message, Dr C should have taken a more proactive approach to track down Dr A's patient. At the least, this would have included telephoning Dr A to enquire further about his patient. Dr C's failure to take a more proactive approach to track down Dr A's patient was an important link in the chain of events that led to Ms B not receiving the timely specialist care that she needed. Dr C should reflect on the part his omission to follow up on Dr A's telephone message had on the unfortunate outcome in this case, and I recommend that he review his practice in this regard.

Additional comment

97. HDC has been advised that changes were made to the way primary care referrals were made to the hospital ED after the new ED opened in 2009. The DHB Chief Medical Advisor advised HDC that there were no written protocols for primary health care referrals to the ED. However, senior ED medical staff expect GPs to contact them, or a junior medical staff member if the specialist is unavailable, before sending a patient to the ED.

[11] Opinion 05HDC14141.

98. It is clear that Dr A's understanding of the management of GP referrals to the hospital was not in accordance with the DHB's expectations. Dr A believed he was to contact the specialist directly, and that he was not to refer a patient directly to ED. The DHB advised that GPs wanting specialist review of a patient had the option of calling the relevant specialist to request an urgent assessment or referring patients to the ED.

99. In my view, it is concerning that there were no clear guidelines or policies for patient referrals between primary care providers and the hospital operating at the time. It would be helpful for primary care centres to have clear policies and procedures available to guide staff on the system for referring acute patients to hospital. However, these policies and procedures cannot be developed in isolation. Primary care centres and district health boards need to work together to develop clear, unambiguous systems for referring patients between primary and secondary services in their respective areas.

100. As this Office has previously stated:[12]

> "It is not for HDC to prescribe the correct solution to these problems. But it is my job to state the obvious: whatever referral system is operating between district health boards, it has to work for patients, who should have justified confidence that referrals will lead to action in sufficient time to treat preventable problems that the public system undertakes to treat."

101. It is reassuring that the DHB has now developed a procedure for primary care referrals to the ED, although it is concerning that this did not occur until March 2012. I encourage the DHB to continue working with the primary care providers in its area to ensure that the new procedure is clearly and unambiguously understood, so as to ensure the seamless provision of services to future patients being transferred between primary and secondary care providers.

Recommendations

Dr A

102. I recommend that Dr A apologise to Ms B for his breach of the Code. A written apology should be sent to this Office by **13 July 2012**, for forwarding to Ms B.

The DHB

103. I recommend that the DHB:

- Report to HDC by **30 October 2012** on the operation and effectiveness of the referral guidelines introduced in March 2012.

[12] 07HDC19869 3 October 2008.

Follow-up actions

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

- A copy of this report, with details identifying the parties removed, except the experts who advised on the case, will be sent to the DHB, who will be advised of the names of Dr A and the medical centre, and to the Royal New Zealand College of General Practitioners, who will be advised of Dr A's name.

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

Appendix A — Independent clinical advice — Dr David Maplesden

"Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B] about the care provided to her by [Dr A]. To my knowledge, I have no personal or professional conflicts of interest.

1. Documents reviewed
1.1 Complaint from [Ms B] received 16 April 2010
1.2 Response from [Dr G] received 24 May 2010
1.3 Response from [Dr A] received 28 June 2010
1.4 Response from [Dr C] received 15 June 2010
1.5 [The hospital] notes regarding current problem
1.6 GP notes including historical reports

2. Complaint
2.1 [Ms B] states that on 16 November 2009 she presented to [Dr A] with *severe shooting pain starting in my right hip going down the back of my leg and behind my knee, I also had pins and needles in my leg and loss of feeling.* [Dr A] diagnosed a prolapsed disc and organised an urgent CT scan. He also advised [Ms B] to rest and she was placed on ACC.

2.2 On 20 November 2009 [Ms B] saw [Dr G] and told her of her history and that she was awaiting a CT scan. She also told her she had lost bladder control since the previous day although her bowels were functioning as usual for her. [Dr G] recommended that [Ms B] see [Dr A] and she saw him a short time later. [Dr A] increased the urgency of the CT scan (to 23 November 2009) and left a message with orthopaedic surgeon, [Dr C], explaining [Ms B's] symptoms. He then sent [Ms B] home.

2.3 On Monday 23 November 2009 [Ms B] attended for her CT scan and shortly after she received a call from [Dr C's] secretary saying that he wanted to see [Ms B] urgently (he had been trying to contact her since Friday 20 November) and *he had been waiting for me to turn up to the emergency department either Friday night or over the weekend as this was a medical emergency*. [Dr C] examined [Ms B] and she underwent emergency disc surgery that afternoon.

2.4 A couple of weeks after the surgery [Ms B] had a relapse of her pain and MRI scan in [city] suggested a further prolapse. She was booked for surgery at the end of January 2010 but instructed to return immediately if she lost control of her bladder again. Unfortunately this did occur and she was undergoing surgery within a few hours of the symptom recurring. At the time of the complaint [Ms B] was undergoing rehabilitation at [a] spinal unit but had ongoing signs of cauda equina syndrome that may be permanent and significantly detract from her ability to function normally and to enjoy life. She wants someone held accountable for this situation.

3. Provider(s) response
3.1 [Dr G] was asked to see [Ms B] on 20 November 2009 as [Dr A] was running late. [Dr G] listened to [Ms B's] history and reviewed the notes and thought it preferable for [Dr A] to review [Ms B] given his previous contact with her and the fact he had recently spoken with

specialist about her case. [Dr G] spoke with [Dr A] who agreed he needed to see her and did so a short time later.

3.2 [Dr A]
(i) [Dr A] apologises for any distress caused to [Ms B] through these events. He has seen her only once since her surgery and she voiced no concerns at his management of her at that visit. He is happy to meet with her to discuss any issues she may have.

(ii) [Dr A] describes [Ms B's] presentations and management by him on 16 and 20 November 2009 (see clinical note summary). Following the initial presentation he was suspicious of a right disc prolapse and contacted orthopaedic surgeon [Dr F] to get advice and endorsement to arrange an urgent CT scan which was done. [Dr A] recorded that [Dr C] would likely see [Ms B] as an outpatient in the public system once the scan was completed.

(iii) [Ms B] presented again on 20 November 2009 — [Dr A] was fully booked but saw [Ms B] after discussing her with his colleague, [Dr G], who had some concerns. After examining [Ms B], [Dr A] *immediately recognised the new development of intermittent bladder loss of control as a further 'red flag' and signal that the situation was worsening.* He rang [the] Hospital, established [Dr C] was on call, and was put through to him on two occasions with no answer from him. [Dr A] then contacted the radiology department and managed to expedite the CT scan for the following Monday.

(iv) [Dr A] states that he then rang [Dr C] again and left a message on the answer phone describing *[Ms B's] symptoms especially the recent development of incontinence…that the CT scan had been brought forward and was booked for early Monday morning…[Ms B's] details if he wanted to call her in earlier than this to ED…informing him that I was faxing through [Ms B's] details as well…My details are available at the hospital if [Dr C] had wanted to get hold of me for more information…I then told [Ms B] to seek further medical assistance if her symptoms got worse over the weekend.*

(v) [Dr A] notes, with the benefit of hindsight, that it was his responsibility to ensure [Dr C] received his message and would not use that method of communication in the future. However, he sincerely believed that he had done everything possible at the time to ensure the orthopaedic service was aware of [Ms B's] predicament and would manage her accordingly, and was following protocol in attempting to contact the specialist rather than just sending the patient in to ED. As a consequence of this event, the issue of communication between primary and secondary care in the district is being examined and will be followed up.

3.3 [Dr C]
(i) [Dr C] was operating on Friday 20 November 2009 and was on call for the weekend 21/22 November 2009. Some time after the conclusion of surgery (after 1700hrs) [Dr C] opened a voice-mail message on his phone from [Dr A]. It indicated [Dr A] was referring acutely a patient with a three week history of back pain and some abnormal neurological abnormalities who had presented today with new urinary symptoms. He had previously discussed her with [Dr F] (another orthopaedic surgeon) and she had been awaiting a CT scan.

(ii) Regarding the call, [Dr C] states *No details were left regarding the name of the patient or any contact details, nor were any details left with regard to contacting the General Practitioner.* [Dr C] assumed the patient would be presenting to ED for him to assess as

would be normal practice. After completing his operating list about 1900hrs on 20 November 2009, [Dr C] called in to ED to see if the patient in question ([Ms B]) had presented. She had not so he left instructions for him to be called as soon as she presented. However, no call was received over the weekend.

(iii) On Monday 23 November 2009 [Ms B] presented to [Dr C's] private clinic stating she had been sent by her GP who had arranged a CT for this day the previous Friday. Staff managed to track down a fax[13] sent by [Dr A] the previous Friday but which had been sent to the wrong fax number and was not at [the private clinic] or the hospital orthopaedic clinics. [Dr C] subsequently assessed [Ms B] and undertook an L5/S1 discectomy that afternoon after which her symptoms initially improved. She required further surgery at a later date after her symptoms deteriorated but did not make a good recovery. *She has ongoing neurological symptoms of significance indicative of Cauda Equina Syndrome and has been referred to [a] Spinal Injuries Unit for assistance. She undoubtedly will have permanent disability as a consequence of her disc prolapse.*

4. Review of clinical records

4.1 There are a variety of historical specialist letters in the GP notes. … There is a letter from [Dr C] to [Dr A] dated 9 June 2005 after [Ms B] presents with persistent low back pain diagnosed as mechanical. [Dr C] notes *Examination revealed some positive Wardell signs which are not typically related to the condition, of course, but do possibly reflect underlying health issues.* Discharge summary from [the Spinal Unit] dated 21 April 2010 concludes, *This lady has suffered from incomplete cauda equina syndrome, poorly correlated with the actual neurological compromise. Clinically there is a component of functional overlay and it was also identified that there is a significant psychological/social situation contributing to her stress…*final follow-up there in six months is recommended.

4.2 GP notes for 16 November 2009 note [Ms B's] history of a fall three weeks previously with persistent right leg pain since then, *sciatic distribution, [numbness] & tingling around foot, weakness & loss R AJ, also SLR 20 deg on R…L leg all OK Dx acute L5/S1 disc prolapse d/w Ortho…[Dr F] for CT and ref* [Dr C]. A CT request is initiated and analgesics prescribed. On 17 November 2009 there is a nurse comment recorded *T in excruciating pain and burning with back pain, does not feel that rx analgesia is cutting the mustard. d/w [Dr A]*. On 20 November 2009 *severe lumbar pain into R leg, sciatic, still nil AJ reflex. Lost control of urine, but no saddle anaesthesia/numbness. Rung and left message with [Dr C], rung CT scan, refaxed letter/copy consult.* On 24 November 2009 [Dr A] records *last evening I rung [Ms B's] hme no. after receiving CT report…her partner advised me she was having operation etc…today [orthopaedic surgeon] rung re contactability of ortho on Friday. I advised him of details of consult & my attempts to contact [Dr C]…I left detailed message on his answerphone etc…refaxed letter & arranged CT! & couldn't do any more.*

4.3 There is a fax from [Dr A] dated 20 November 2009 1452hrs and addressed to *[Dr C] Private.* It contains a copy of the consultation note from 16 November 2009 with a handwritten addition: *returned ++ pain, now loss of urinary control, no saddle anaesthesia, rung CT & ortho again, rung [Dr C] — left message. 9.15am CT Mon booked.* [Ms B's] demographic details and address are noted but there is no typed contact phone number for

[13] Dr Maplesden made the comment about the retrieval of Dr A's fax and Ms B's presentation at Dr C's private clinic before the information provided by Ms D was obtained.

her. There are however two handwritten telephone numbers across the top of the fax which may belong to [Ms B]. [Dr A] has placed his stamp to identify the sender — this is partially obscured but there is enough detail to recognise his surname.

4.4 Letter from [Dr C] to [Dr A] dated 23 November 2009 — *Thank you for referring urgently this young lady. As you are aware you left a message on my phone on Friday but unfortunately I could not track [Ms B] down…I feel most uncomfortable, as I am sure you did on Friday, about her status with urinary incontinence and have admitted her urgently. The CT organised prior to the appointment with me shows a central disc prolapse of L5/S1 with almost certainly a moderate degree, at least, of cauda equina compression.*

4.5 Imaging — 23 November 2009 CT: *Significant L5-S1 disc protrusion centrally and a little to the right of centre. Impingement on S1 nerve root.*

3 December 2009 CT: *L5-S1 there was a prominent bulging disc annulus…there may well be some compression of the emerging right S1 nerve root.*

14 December 2009 MRI: *Probable recurrent/residual L5/S1 right paracentral disc extrusion.*

12 January 2010 CT: *Appearances have slightly improved from the post-operative MRI…residual right L5/S1 subarticular recess stenosis.*

4.6 [The] Hospital discharge summary for admission of 23 November 2009 notes *Examination in ED found there to be weakness in most ranges of movement in the right but not the left leg, altered sensation in the L5 and S1 dermatomes, absent ankle jerk on the right, normal perianal sensation and intact anal tone.* Discectomy and decompression are performed that afternoon. Subsequent progress is as per the response, with evidence of recurrence of disc prolapse noted in a letter of 23 December 2009 and requirement for further surgery. Orthopaedic Clinic letters post operatively indicate [Ms B's] persisting symptoms of pain (requiring Oxycontin, Gabapentin and Voltaren), bowel and bladder symptoms and a right foot drop.

5. Comments

5.1 Background: The New Zealand acute low back pain guidelines[14] state: *Features of Cauda Equina Syndrome include some or all of: urinary retention, faecal incontinence, widespread neurological symptoms and signs in the lower limb, including gait abnormality, saddle area numbness and a lax anal sphincter… Cauda Equina Syndrome is a medical emergency and requires urgent hospital referral...All patients with symptoms or signs of Cauda Equina Syndrome should be referred urgently to hospital for orthopaedic or neurosurgical assessment.* There are few surgical emergencies in the treatment of back pain but this is one that, in my opinion, is common knowledge and should be recognised by all GPs. [Ms B's] presentation was sufficiently suspicious for Cauda Equina Syndrome for the diagnosis to be clear, although her past history of a variety of neurological symptoms with significant functional overlay could have influenced the diagnosis somewhat and appears to be an ongoing issue.

5.2 Management by [Dr A]: [Dr A] has documented a competent clinical assessment of [Ms B] on 16 November 2009. He suspected a significant disc prolapse and sought specialist

[14] NZGG. *New Zealand Acute Low Back Pain Guidelines* 2003

advice and assistance with expediting a CT scan at that point. He provided analgesia for [Ms B]. His management of [Ms B] was very good and consistent with expected standards. On 20 November 2009 he again undertook a competent and appropriate assessment of [Ms B] and considered the diagnosis of Cauda Equina Syndrome (CES). He realised the need for urgent assessment with imaging in this situation and sought initially to make a direct referral to [Dr C] (which was unsuccessful), and then to expedite the CT scan. He left a message with [Dr C], the content of which is outlined in 3.2(iv) but disputed by [Dr C]. He faxed details to the orthopaedic service although the number was incorrect and the fax did not arrive at the correct destination. He was confident that, on receiving his message, if [Dr C] thought [Ms B] should be seen sooner than after the CT scan on Monday 23 November 2009 he would contact her to come in to ED. He advised [Ms B] to go to ED if her symptoms worsened in the weekend and she had not heard from [Dr C]. In my opinion, [Dr A's] duty of care was to ensure (rather than assume) that [Ms B] would receive an orthopaedic review and appropriate imaging on Friday 20 November 2009 after she presented with a clinical picture suggestive of CES. This was a potential orthopaedic emergency and it was inappropriate to suggest that leaving an assessment until Monday was reasonable. I am saying this without hindsight basis — orthopaedic emergency in any context means immediate assessment is indicated. If [Dr A] was reasonably confident that [Dr C] would act on the phone message left for him in a timely fashion i.e. see [Ms B] immediately, he should have told [Ms B] to present directly to ED if she had not heard from [Dr C] by the end of that working day. It was not sufficient to tell her to present to ED only if her symptoms worsened over the weekend. Ideally, she should have been referred immediately to ED once [Dr A] was unsuccessful in his attempts to contact [Dr C]. I acknowledge that [Dr A] was competent in his clinical assessment and diagnosis of [Ms B], and had a good standard of clinical documentation, and that he went to considerable effort to expedite [Ms B's] imaging and assessment. These are all mitigating factors but they do not cover the fact that it was [Dr A's] duty to ensure [Ms B] received a specialist review on 20 November 2009 and he failed to do this. His decision to assume a voice message and fax to the specialist would result in [Ms B] receiving timely care was an error of judgement that may have significant repercussions for [Ms B]. Under the circumstances, his management of [Ms B] departed from expected standards to a moderate degree. … [Dr A] has acknowledged he will change his practice when attempting to access urgent specialist services in the future. I do not feel that his clinical competency is an issue and I do not feel that any additional remedial actions are indicated.

5.3 Management by [Dr C]: [Dr C] received a voice message from [Dr A], the exact content of which is subject to debate, between operating on patients in the late afternoon of 20 November 2009. There was evidently enough detail in the message to lead [Dr C] to expect that the patient would be presenting to ED for an assessment. In my opinion, had [Dr A] adequately recognised that immediate assessment was warranted the message should have stated that the patient would be presenting to ED as an emergency with suspected CES. In my opinion, it was quite reasonable for [Dr C] to assume that if a practitioner suspected CES in a patient he would refer them directly to ED, having been courteous in informing the specialist of the patient's imminent arrival. In retrospect, when the patient had not arrived by perhaps the morning of 21 November 2009, it might have been reasonable for [Dr C] to have contacted [Dr A] to clarify the situation. However, there are several reasons why the patient may not have presented including decision to seek attention elsewhere and unexpected resolution of the symptoms. I do not think it was reasonable to expect [Dr C] to 'chase up' [Ms B] to see why she had not attended whether or not [Dr A] had left her contact details in

the phone message. When [Ms B] did attend [Dr C] on 23 November 2009, the exact mechanism for her getting to his private rooms being somewhat unclear, he recognised the urgent nature of her predicament and subsequent management by him was appropriate. …

6. Opinion

6.1 On the basis of the records available to me, and referring to comments in section 5, I am of the opinion that the management of [Ms B] by [Dr A] departed from expected standards to a moderate degree.

Dr David Maplesden, Clinical Advisor, Health and Disability Commissioner"

Appendix B — Independent orthopaedic advice — Dr Garnet Tregonning

"This report relates to the most unfortunate situation where a 29 year old lady developed a Cauda Equina symptom secondary to an L5/S1 disc herniation following a fall in the shower. She developed neurological symptoms some 4 days following the fall and in the 4 days after that developed symptoms of urinary incontinence.

It is clear to me that when she saw her General Practitioner [Dr A] on the Friday afternoon the 20th of November he correctly recognized that she had a major problem in that she had developed the new symptom of loss of bladder control. As you know, when she was seen on the 16th of November 4 days earlier she had symptoms consistent with significant Lumbar Disc Herniation with absence of ankle jerk and marked reduction of straight leg raising.

It is also apparent that [Dr A] certainly tried to contact [Dr C] the Orthopaedic Consultant on-call that day. It is noted that he had previously spoken to another Orthopaedic Surgeon [Dr F] after the initial presentation with the Sciatica.

It is also clear to me that [Dr A] did make significant attempts to contact [Dr C]. He claims that he left a message on [Dr C's] phone including the patient's contact details, (in case '[Dr C] wanted to see the patient in the Emergency Department'). He also faxed a referral through to [Dr C's] private clinic.

From [Dr C's] perspective, he did acknowledge that he received a message from the General Practitioner at about 5pm whilst he was operating. He acknowledges that he was aware that the patient had developed urinary symptoms. However, [Dr C] claims that there were no details of the name or contact details of the patient. He also stated that he had assumed the patient had been referred to the Emergency Department which he stated was standard practice.

After he completed his operating list that evening he attended the Emergency Department looking for the patient who had not attended. He discussed with the Medical Officer in the department the fact that he had expected to see the patient and informed the doctor to contact him as soon as the patient attended. He states that over the subsequent weekend he had received no response.

[Dr A], however, stated that he did identify the patient and felt that [Dr C] 'should have contacted him when the patient did not present at the Emergency Department'.

It is most unfortunate that the phone message was not retained so that we can get the full details.

Unfortunately I believe that this patient has 'fallen between the cracks' and that there are deficiencies on the part of both the General Practitioner and [Dr C] the Orthopaedic Surgeon. In saying this I do acknowledge that it is easier after the event to identify deficiencies. With respect to [Dr C], I believe he should have made attempts to track down the patient either that Friday evening and certainly over the subsequent weekend. I believe that his actions in relation to her care departed from the expected standard as a mild departure.

Garnet Tregonning F.R.A.C.S., F.R.C.S.(C) Orth.
ORTHOPAEDIC CONSULTANT"

Appendix C

Consultation

Patient:
Address:
DOB:

Provider:
Date: 16 Nov 2009
Type: Consult In Surgery

Subjective
3wk ago slipped backwards & braced herself with arms , acute R leg pain , initially not so bad , kept working but last 4d , constant day & night , sciatic distribution , numbness & tingling around foot , weakness & loss R AJ , also SLR 20deg on R , L leg ok

Objective
dx acute L4/5/S1 R disc prolapse
d/w Ortho.. or CT & ref RW
1wk off work

Out Box: Radiology Referral
Rx: 100 - Codalgin Tab - 2 tabs, Every Four Hours
Rx: 60 - Diclofenac Sodium 75mg Long-acting Tab - 1 tabs, Twice Daily

Acc No:

28/10/09.

20/11/09 -

Refused. rt pain

now loss of urinary control

- No saddle anaesthesia

- ring CT or ortho again.

- left message

915am CT booked