

Urologist, Dr D
Southland District Health Board

A Report by the
Health and Disability Commissioner

(Case 04HDC13909)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	General practitioner
Dr B	Oncologist
Mr C	Consumer
Dr D	Provider/Urologist
Dr E	Urological surgeon
Dr F	Senior Executive
Southland District Health Board	Provider

Complaint

On 17 August 2004 the Commissioner received a complaint from Mr C about the services provided by Southland District Health Board (“SDHB”) and urologist Dr D. A further detailed letter of complaint was received from Mr C’s lawyer, on 29 November 2004. An investigation into the following issues was commenced on 27 April 2005:

Dr D

- *Whether Dr D provided Mr C with adequate information, including —*
 - (a) *the estimated time within which treatment would be provided; and*
 - (b) *Mr C’s treatment options.*
- *Whether Dr D took adequate steps to ensure that Mr C was appropriately managed between his placement on the urgent waiting list for First Specialist Assessment at Southland Hospital Urology Service, and his appointment for his First Specialist Assessment.*

Southland District Health Board

- *Whether Southland District Health Board provided Mr C with adequate information about:*
 - (a) *the estimated time within which treatment would be provided; and*
 - (b) *Mr C’s option of seeking private treatment.*
- *Whether Southland District Health Board took adequate action to ensure that Mr C received timely treatment following Dr D’s referral in September 2002 to the Southland Hospital “urgent” waiting list for First Specialist Assessment.*

Information reviewed

- Mr C's medical records from SDHB
 - Mr C's medical records from Dr A
 - Service Specification, Hospital Specialist Medical and Surgical Services, Southland District Health Board
 - Mr C's ACC records
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Information gathered during investigation

Introduction

It is well recognised within the health sector that there is insufficient public funding to meet the immediate health needs of all New Zealanders. It is inevitable that not all patients who require treatment will be able to be seen, and some patients may spend a significant time period waiting to be assessed and treated in the public sector. In this environment, it is essential that patients waiting for assessment and treatment in the public sector receive appropriate care and management until such time as they are able to be seen.

This case explores the responsibilities of providers in the management of patients waiting for a First Specialist Assessment ("FSA") in the public system. In particular, it examines the relative responsibilities for the prioritisation and ongoing management of patients waiting for FSA appointments, and the systems that should be in place to ensure that patients do not fall through the cracks.

Relevant background

There are some extenuating factors, which need to be briefly discussed to set the case in context.

Relationship between Dr D and Southland District Health Board

In Invercargill, where this complaint arose, there was one urologist, Dr D, practising at the public hospital (Southland Hospital). Dr D also saw private patients. Dr D advised that from the time of his appointment as urologist at Southland Hospital in 1991, his workload significantly increased. Dr D claimed that his volume of FSAs rose by 238.7%, operations by 70.4%, and follow-up volumes by 80%. However, his contractual hours did not increase. According to Dr D, although he worked overtime, the large number of referrals meant it was not physically possible for him to see every patient as quickly as he would have liked within his contractual hours. This resulted in patients waiting significant periods of time for their FSA appointments with Dr D.

Southland District Health Board ("SDHB") acknowledged that the urology contract volumes increased during Dr D's time at Southland Hospital, but submitted that the increase was not by the margins suggested by Dr D. In addition, it noted that his

output volumes were decreasing. SDHB further advised that it did not expect Dr D to deliver the increased volumes himself. In 2003 Dr D and SDHB commenced discussions about the management of the increased urology workload, which was by then more than one consultant could achieve within the allocated contractual hours. The issue was acknowledged and options discussed. Dr D had offered to complete the backlog of patients by working longer hours on a fee-for-service basis, as a solution to the waiting list problems. The SDHB advised that it considered Dr D's proposal, but was concerned that it was only a short-term solution. It was keen to find a more appropriate long-term solution to what was becoming a chronic problem with the FSA waiting times. The DHB advised that it was cognisant of its duty of care to its community to provide a long-term sustainable service. It therefore investigated the options of appointing another urologist and forming an agreement with a second District Health Board. However, Dr D was reportedly unco-operative in facilitating these options. Ultimately, no mutually agreeable solution was reached.

The failure of these discussions reflected the negative relationship between Dr D and SDHB. Dr D felt unsupported by SDHB, whereas SDHB had concerns about Dr D's control and management of the urology service. SDHB was concerned that the backlog was due, in part, to Dr D's inappropriate prioritisation of patients on the waiting list (for example, prioritising over 50% of patients referred to him as "urgent"). The discussions became heated and personal, and some took place in the public forum (including in the *Southland Times*). As a result, Dr D resigned on 18 May 2004.

Urology FSA waiting-time data

The Ministry of Health provided the following information regarding the number of patients waiting for an FSA in the urology department at Southland Hospital:

- in 2002 SDHB had 288 patients waiting for an FSA, with 166 (58%) waiting longer than six months;
- in 2003 the number of patients had increased to 384, with 246 (64%) waiting longer than six months;
- in 2004 the number of patients had increased to 466, with 311 (67%) waiting longer than six months;
- in 2005 (after changes were made) the number of patients had been reduced to 59, with none (0%) waiting longer than six months.

SDHB said that the ratio of new patients seen (FSA patients) to returning patients seen at Southland Hospital was 1:9, compared with the national average of 1:2.

Case background

Referral to Urology Clinic

Mr C, a 61-year-old man, visited his general practitioner, Dr A, on 24 June 2002 with urinary problems. The notes record that he was suffering from frequent micturition

(the passing of urine) and nocturia (excessive urination at night), and that he had a non-tender large prostate with “normal architecture”. Dr A ordered a prostate specific antigen (PSA) test and drafted a letter of referral to Dr D at the Southland Hospital Urology Clinic for further assessment. (A PSA test measures the level of PSA — a protein produced by the cells of the prostate gland. Because prostate cancer can increase PSA levels, it is used as a test to detect prostate cancer.)

The letter of referral stated:

“Dear [Dr D]

I wonder if you would see [Mr C], who suffers with symptoms of benign prostatic hypertrophy. He has got very frequent micturition, where he is only passing a small amount of liquid at a time.

His normal nocturia is about three times a night, but if he drinks two handles of beer he is up to the toilet every quarter of an hour.

On examination he has got a non-tender large prostate with normal architecture.

I wonder if you could see him at your earliest opportunity as I feel he will probably get worse over time.”

Handwritten comments on the letter noted that Mr C’s 24 June PSA result was 51.1ug/L HH. This is a significantly elevated PSA result, with a normal result being less than 4.1. This PSA result indicates a high likelihood of cancer, although cancer is not the only potential cause of an elevated PSA.

Mr C advised that he was not aware of the significance of the PSA test result at that time. However, in October 2004 Dr E, urological surgeon, advised him that a PSA over 50 indicates a 100% chance of cancer, and a high chance of metastases.

Further tests required

The letter of referral from Dr A was received at the Urology Clinic on 27 June 2002. Dr D recalled that he thought the referral letter was incomplete, with no clear description of an examination by Dr A. There are a number of illegible handwritten notations on the referral letter dated 7 July 2002 that appear to be signed by Dr D, including the notation “see urgent”.

On 22 July 2002 the Urology Clinic wrote to Mr C acknowledging receipt of the referral from Dr A. The letter noted that Dr D would like Mr C to undergo some further investigations to obtain the clinical information needed to prioritise him for FSA. Mr C was advised that Dr D would contact him about the required tests. The letter was copied to Dr A.

It is unclear exactly when Mr C was contacted about the tests required by Dr D. However, it appears that the tests undertaken included a flow test, ultrasound, and a further PSA test. The tests were not performed by Dr D, but he was informed of the results and summarised them in a letter to Dr A dated 25 September 2002 as follows:

“... flow test was carried out recently and his flow is quite satisfactory. He voided 504ml over 40 seconds with a maximum flow of 19, but the average is 12.6l/sec. This flow suggests complete bladder emptying. Ultrasound of the kidneys show no abnormality and the bladder empties completely in the postmicturition phase. His prostate appears to be small, about 25g in size. Urine shows no evidence of infection. However, the PSA was 51.5 on 26 June 2002, and has now reduced to 44.6 on 12 September 2002.”

Mr C advised that Dr D was wrong to say he was emptying his bladder completely. Mr C recalled that at the time the test was performed the person performing the test told him that his bladder was not empty and asked him to go to the toilet again to empty it.

Prioritisation of referral

In his 25 September 2002 letter to Dr A, Dr D noted that he had prioritised Mr C as “urgent” for an FSA at the Urology Clinic. He noted:

“In view of the symptoms and the elevated PSA, although he is emptying his bladder completely, [Mr C] has been placed on the urgent waiting list to be seen and I will therefore see him as soon as his turn comes up, but this is unlikely to take place for several months due to the extent of the waiting list.”

Dr D advised that although Mr C’s PSA had reduced from 51.1 to 44.6 in September, he gave Mr C the “benefit of the doubt” and prioritised him as “urgent”. The referral was backdated to the day of Mr C’s referral in June 2002. Dr D claimed that he expected to see Mr C for his FSA within six months.

Follow-up

Although a copy of the 25 September 2002 letter was copied to Mr C, he apparently did not receive it. Mr C also said that he was not aware that his PSA was 51.5 ug/L and, even if he had been, he would not have understood its significance.

Dr A said that he told Mr C that they would have to keep an eye on his PSA because it was high. Dr A checked Mr C’s PSA results, which were as shown:

- 24 March 2003 PSA 49ug/L
- 27 June 2003 PSA 49ug/L
- 26 April 2004 PSA 70ug/L
- 19 May 2004 PSA 73ug/L

Dr A said that he told Mr C the results of his tests and sent the results to the Urology Department. Mr C advised that he is “absolutely clear” that at this stage he had no idea of the significance of the PSA test results, or what a PSA test measured. In addition, he noted that he was not advised of the possible need for urgent treatment, or of the option of consulting Dr D privately. Had he known of the significance of the test results, he would have sought private treatment.

There is no record that the Urology Department ever received the results of the PSA tests taken by Dr A.

Mr C and Dr A received no further communications from Southland Hospital in relation to the referral and appointment for FSA. Dr A did not take steps to follow up the referral directly with the hospital. Mr C said that, because he did not know the significance of a raised PSA and remained well, he had no reason to follow up the referral.

Dr A advised that the urology waiting list had been the subject of many peer review meetings. In particular, in 2003 he was appointed to a Waiting List Committee in an attempt to address the issues with the waiting list. The Committee was made up of another GP, the GP liaison officer, the waiting list co-ordinator, head of surgical services and Dr D. The Committee had three meetings, but was unable to progress the matter. Dr A noted that on previous occasions he tried reminding the Urology Department that a patient had not been seen but such letters received a “terse” reply. Dr A noted that on previous occasions personal approaches from himself and other GPs had resulted in an outcome detrimental to the patient’s interests.

Dr A considered that continuing to send Mr C’s high PSA test results to Southland Hospital Urology Department would have been enough of a reminder, but unfortunately the list “was controlled by one person”. Dr A saw his role as continuing to keep a watchful eye over Mr C while Mr C waited for an appointment for FSA.

Worsening condition and further referral

By April 2004 Mr C’s urinary problems were worsening, and on 23 April 2004 he consulted Dr B, an oncologist, who was working as a locum for Dr A. Dr B noted in the clinical record that Mr C had a PSA of 50 and that he had been referred to Dr D. It was also recorded that Mr C’s prostate felt hard and “possibly malignant”. Dr B noted that Mr C needed an urgent appointment, and would seek private treatment if necessary. Dr B phoned Dr D, who agreed to see Mr C urgently. His telephone call to Dr D was followed up by a letter of referral, dated 26 April 2004, which stated:

“I wonder whether I could perhaps jog your memory regarding [Mr C], who was referred to you by [Dr A], in October 2002, with a PSA of 51, he was reviewed by your department and placed on your urgent waiting list.

Since that time he has not received an appointment although he does tell me that he did receive a letter at some point from Southland Hospital indicating that he no longer needed to be seen.

He is now complaining of increased symptoms of prostatism and given the fact that his PSA although stable is extremely elevated, I do wonder whether he would warrant your further attention.”

Dr B’s referral to Dr D implied that Mr C had received a letter from SDHB informing him that he was no longer on their waiting list. Neither Mr C, Dr A, SDHB nor Dr D has been able to provide the letter, and Dr D has denied any knowledge of it.

As a result of Dr B’s referral, Mr C received an appointment to see Dr D on Monday, 24 May 2004, at 10.30am. However, before Mr C could attend this appointment he received notification that Dr D was no longer employed by SDHB.

Referral to Dunedin and subsequent treatment

On 21 May 2004 Dr B reviewed Mr C again. He noted in the record “PSA rising significant prostate symptoms”, and he referred Mr C urgently to Dr E, a private urologist.

Mr C was reviewed by Dr E on 27 May 2004. Dr E conducted a urinary flow test and ultrasound, a rectal examination, and took some biopsies. Dr E advised Dr B by letter dated 27 May 2004:

“... ”

[Mr C] did a urinary flow test today which is obstructed, the peak flow being 13 cc’s per second for a voided volume of 544. Ultrasound after this void revealed that he had not emptied his bladder completely, the estimated volume in the bladder being 196mls ... Transrectal ultrasound revealed the prostate gland to be just a little enlarged, estimated volume 28mls, and on the ultrasound the gland did not look normal, but on the left hand side the gland having a rather patchy hypoechoic appearance, suggestive of malignancy.

I then took three biopsies from the right prostate lateral lobe and four from the left. To the naked eye the biopsies from the left looked full of cancer. I told the patient to ring me at 4.30pm tomorrow when the result of the biopsy will be known and I will be very surprised if it is not cancer. If cancer is confirmed then I think he might be a candidate for radiotherapy, provided there is no evidence of spread. He will need a bone scan and a CT scan and because you are employed by Southland Hospital you would be the best person to organise those scans.”

The biopsies revealed that Mr C had adenocarcinoma of the prostate, “Gleason Grade 9, involvement 100% of prostate, Stage TIII NXNX”.

Management of waiting list

Mr C waited 22 months for his FSA, without being given an appointment time. Other than Dr D's letter of 25 September 2002, no attempt was made to give Mr C any information about his clinical condition, options, or an estimate of the time within which he could expect to be seen. He received no information from Dr D or Southland Hospital after 25 September 2002 when his GP understood him to be on the "urgent" waiting list for FSA.

It appears that there was a significant level of confusion as to who was responsible for managing patients on waiting lists, and the extent of such responsibility.

In Mr C's opinion, Dr D had arranged investigations and further assessment and therefore had taken responsibility for Mr C's care and management. Mr C expected to receive appropriate follow-up care from Dr D. He was unaware of the significance of the elevated PSA and the need for urgent attention until April 2004 when he was reviewed by Dr B. Mr C is concerned about the impact the delay in attending his high PSA level had, and will continue to have, on his health. He noted, "Having this high PSA for so long meant I have a far greater chance of it becoming metastatic and to spread elsewhere."

Dr D told my Office that on 25 September 2002, when he informed Dr A that Mr C was on the "urgent waiting list", he expected Mr C to have his FSA within six months. However, he noted in his letter to the GP on 25 September 2002 that the FSA was "unlikely to take place for several months due to the extent of the waiting list". Dr D never saw Mr C. He considered that, until such time as a patient is physically seen, it remains the duty of the referring general practitioner to keep a watch on the patient. The general practitioner should notify the Urology Department if the patient's condition deteriorates during the waiting time. Although he did not see Mr C for an FSA within six months, as he had expected when he wrote to Dr A in September 2002, Dr D did not inform Dr A or Mr C because "it was the responsibility of Southland Hospital Management, to inform the patients and their General Practitioner of any delay in providing the services of which the hospital Management were well aware". Dr D advised:

"[Mr C] always knew that he could see me privately in my rooms. It was not for me to ask him to see me at my rooms as I would have been accused of touting and coercing patients to my private practice. His general practitioner, [Dr A], should have given him this option which he knew existed, but he did not."

In contrast, Dr F, a senior executive of SDHB at the time of these events, submitted that it is the clinician's role to manage the patient and waiting list for FSAs. The question of prioritisation for an FSA was a clinical one, made by the responsible clinician.

In 2002, as part of its funding agreement with the Crown, SDHB was required to comply with the national service specification for "Hospital Specialist Medical and

Surgical Services” (Ministry of Health, 2001). Clause 8 of the service specification imposed the following quality requirements:

“QUALITY REQUIREMENTS

The service is required to comply with our general terms and conditions and our provider quality specifications. The following specific quality requirements also apply.

8.1 Elective Services

(a) Implementation

You will continue to develop, implement and manage booking systems for all medical, surgical and diagnostic services where there are, or may be people waiting.

You agree to develop and implement booking systems which are in accordance with the Crown’s objectives and directives to the [Ministry of Health] and the performance standards described below.

(b) Performance Expectations

...

vi Where you cannot meet the ongoing demand for specialist assistance and advice within six months of referral within the funding provided you will:

- a) Prioritise referrals and requests for assistance to ensure that patients with the greatest need are seen within the resources available.
- b) Notify referrers and patients of the ability or inability to provide services within the minimum standard of six months.
- c) Provide referrers with information that indicates the level of need or priority that can be serviced together with referral or management guidelines to enable general practice to manage the patient’s plan of care and review or reassess their condition as appropriate.”

Dr F advised that at the time of these events the urology waiting list for FSAs at Southland Hospital was 12–18 months with 330 patients waiting, and Dr D had prioritised 58% of those patients as requiring an urgent appointment. (It is noteworthy that this information does not indicate how many of the 330 patients had been waiting more than six months, or what proportion of that sub-sample was classified as “urgent”.) In Dr F’s view, prioritisation meant that patients with the greatest need must be seen first. Dr F advised:

“It is unclear why [Dr D] did not inform [Mr C] of the true likely waiting time as opposed to the vague description of ‘several months’. It is also unclear why [Dr D] did not follow the service specification when it was clear that [Mr C] would not be seen within six months. While management tracks the trends and statistics, individual cases such as [Mr C’s] would only come to its attention when a complaint is received. In this instance by the time it was brought to management’s attention [Dr D’s] employment had already been terminated.”

ACC claim — comments on management

Mr C lodged a claim with ACC for medical misadventure in respect of delay in diagnosis of prostate cancer and in relation to osteoporosis subsequent to treatment for prostate cancer. His claim was declined, on advice from ACC urology advisor Dr Nixon that 18-month delay in diagnosis of his prostate cancer did not affect Mr C’s treatment, outcome and diagnosis, and that osteoporosis is a known side effect of the hormone-lowering agents Mr C was prescribed. Of interest to this case are Dr Nixon’s comments on the delay in providing services to Mr C:

“
...

As far as the delay in diagnosis is concerned I believe that the time periods involved were excessive. [Mr C] was referred to the Urology Unit at Southland Hospital in June 2002 and by April 2004 still had not been seen by the Clinic Urologist, [Dr D] ...

Correspondence from [Dr D] from Southland Hospital in September 2002 indicates that he felt that [Mr C’s] problems were serious and that he would be given an urgent priority for review in the clinic. The final sentence of this letter to the GP and [Mr C] indicates that the appointment would be unlikely to take place for several months due to the extent of the waiting list.

[Mr C] was not seen at all by [Dr D] in the Urology Department.

[Dr D] wrote a report to ACC on the 30th May, 2005. This was in reference to the claims made by [Mr C] in regard to the delay in diagnosis of the prostate cancer. The letter does not provide any explanation for the failure to review [Mr C] in clinic. Most Urology clinics in the country are able to see their urgent category clinic patients within a few months. [Dr D’s] letter indicates that [Mr C] would expect to be seen within several months.

Without an explanation we therefore are only able to make assumptions. [Dr D] may have had an enormous number of urgent referrals around that time although it is hard to imagine that he would still be working through them nearly two years later. After initially being reviewed in the clinic [Mr C’s] referral letter may have been misfiled and accidentally inserted in to a lower priority clinic file. We all know that some patients with low priority type problems, in fact, take years to be

reviewed by the Urology clinic. In most Outpatient clinics in New Zealand, when a patient waits more than six months, correspondence will be sent back to the GP and/or the patient, indicating that this is the case and some suggestions for management will be discussed or the GP will be asked to review the patient to ensure that their symptoms haven't worsened. This did not occur in the case of [Mr C]. [Mr C's] referral letter may have been totally misplaced following his initial review by the staff of the Urology clinic. ...

I am surprised that the correspondence from Southland Hospital Management does not include an explanation as to why [Mr C] had to wait more than 18–19 months. I think it would have been reasonable in correspondence of this nature to have provided some information in regards to clinic waiting times in Southland.

...

Having clearly identified that a delay occurred the question is, does this have any implications as far as morbidity and mortality are concerned. During the 18 months between initial referral and subsequent review [his] PSA rose from 51 or 44 through to 69. It is likely that if cancer was diagnosed soon after initial referral that the grade of cancer or Gleason scoring of the cancer would have been exactly the same. The grade of cancer typically does not change during the natural history of a disease such as prostatic cancer. However the cancer would have grown in volume and at some stage metastasised. With a PSA of 50 and a high grade cancer, such as [Mr C] had, it is highly likely that even at initial referral that he had a locally advanced cancer. This means that the cancer has or may have already spread outside the capsule of the prostate into the surrounding tissues or that it may have become metastatic and spread elsewhere in the body. The treatment offered to him at that time would have been exactly the same as that which he subsequently received ...

It sounds as though the number of patients referred to the Urology Clinic was excessive and it doesn't sound as though all of them can be seen. However it is hard to understand how a patient with an urgent prioritisation could not be seen. It is possible that the referral letter somehow got misplaced after the initial review in the Urology Clinic. We unfortunately have no information at all about the systems that are in place to ensure that these letters are filed, stored and reviewed in an appropriate fashion. This, I believe, should be the responsibility of the Management Team at Southland Hospital. It is also their responsibility to ensure that the staffing of these clinics is adequate and this potentially could also have been a problem.

On balance, it would appear that there is a failure by [Dr D] to observe a standard of care or skill reasonably to be expected in the circumstances ...

There is evidence to suggest that the delay in diagnosis is at least in part the fault of the Southland Hospital (the organisation). The system set up in the clinic to

review patients on clinic waiting lists was questionable. The Hospital should have a system set up whereby patients on the urgent waiting lists and some of the less urgent waiting lists should be reviewed. This should not specifically be the duty of the Urologist involved but should be the responsibility of the senior Clerical nursing staff ...

I am also surprised that [Mr C's] GP, [Dr A], did not follow up on his original referral in June 2002. He presumably was aware that [Mr C] had not been seen by [Dr D] and as such I would have expected that he perhaps would have looked at getting in touch with [Dr D] either by phone or via more correspondence."

Subsequent action taken by SDHB

SDHB advised that it has gone to "extraordinary lengths to transform its Urology service and has been motivated at all times by a genuine desire to improve services to its community".

Following Dr D's resignation, SDHB sought to address the significant list of patients awaiting FSAs. The SDHB conducted a urology super clinic on the weekend of 13 November 2004, with the assistance of seven urologists from other parts of the country. The SDHB has now dramatically reduced the waiting time for FSAs, with no patients waiting longer than six months. As at 30 December 2005, 25 patients were waiting for FSAs, 22 of whom had been waiting less than one month.

Furthermore, SDHB advised that it has implemented long-term solutions for the oversight and management of patients waiting for FSAs in the Urology Department. In particular, it has appointed a urology nurse who monitors and manages the FSA waiting list, in conjunction with an external urologist, and a new permanent full-time urologist has been appointed.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

- 1) *Every consumer has the right to have services provided with reasonable care and skill.*

...

- 5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

RIGHT 6

Right to be Fully Informed

- 1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —*
 - a) *An explanation of his or her condition; and*
 - b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*
 - c) *Advice of the estimated time within which the services will be provided; ...*

Opinion: Breach — Dr D and Southland District Health Board

Duty of care

Once a clinician undertakes to provide services to a patient, that clinician owes a duty of care to the patient. The duty of care is to exercise reasonable care and skill in the care and treatment of the patient. As noted by Lord Diplock: "It is a single, comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement."¹

¹ *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] AC 871 at p 893, per Lord Diplock.

In the specialist setting, this applies from the initial act of reviewing a request for a first specialist appointment and prioritising that request, through to providing an assessment and treatment or referring that patient back to the referring GP if an appointment within six months is unlikely.

In my view, Dr D, SDHB and Mr C's GP owed Mr C a duty of care to ensure his appropriate management pending his FSA appointment. To meet their duty of care to Mr C, Dr D and SDHB needed to ensure that:

1. Mr C was appropriately prioritised and seen in accordance with that priority;
2. Mr C and his GP were advised when to expect an appointment for FSA, and given adequate information about the need for his GP to monitor his condition and notify the urology service if his condition deteriorated; and
3. Mr C and his GP were advised of the option of private assessment and treatment.

The key question in this case is how to attribute responsibility between the patient's GP, the specialist, and the DHB.

General practitioners are responsible for the day-to-day clinical management of their patients. When a GP refers his or her patient to a specialist for assessment in the public system, the specialist (upon receipt of the referral) assumes a duty of care to appropriately prioritise and assess the patient. This is confirmed by the national service specification, which states that if a patient is referred for specialist assessment it is the specialist's responsibility to prioritise that patient in relation to all other patients awaiting FSA. Following referral to the public system, the DHB also assumes a duty of care towards the patient. The DHB's duty of care lies in the appropriate management of FSA waiting lists. DHBs are responsible for ensuring patients and their GPs are given clarity about whether they will be seen, and if so when; and, following assessment, when treatment will be provided. If the number of patients seeking to be seen for FSAs exceeds the resources available, it is the DHB's responsibility to advise the patient and the referring GP that the patient may not be seen within six months, if at all, in the public system. Throughout the referral process, the patient's GP retains a duty of care for the ongoing clinical management of the patient pending specialist assessment.

Dr D

Management of Mr C

Mr C was referred to Dr D with an elevated PSA in June 2002. Dr D arranged for Mr C to have further investigations to enable him to prioritise the referral. Based on the results of the investigations, Dr D prioritised Mr C as "urgent" for an FSA and advised Mr C and his general practitioner, Dr A, accordingly on 25 September 2002.

Dr D and Mr C never met personally as doctor and patient. Dr D argued that the responsibility for managing Mr C lay with SDHB, on the basis that prior to the FSA

Dr D had not assumed responsibility for the care and treatment of Mr C and, therefore, no duty of care existed.

I do not accept Dr D's argument. A clinician does not have to be in direct contact with a patient to owe that patient a duty of care, and a clinician can accept a patient into his or her care without ever seeing that patient.² As noted by Dr David Geddis, a specialist assumes responsibility for a patient for the purposes of establishing a duty of care when the information in the referral letter is considered, and a priority allocated.³ Dr D reviewed Dr A's 24 June 2002 referral, assessed Mr C's condition on the basis of the information provided, identified the necessity for further investigations, ordered the investigations, and reviewed the investigations. He then undertook to see Mr C for an FSA. By these actions, Dr D became subject to a duty of care for Mr C.

Dr D was required to appropriately prioritise and assess Mr C given the clinical information available to him at the time. Dr D prioritised Mr C as "urgent", which was warranted given the available clinical information. Thus Dr D had undertaken his first prioritisation task — initial assessment and assignment of a priority to Mr C. The second prioritisation task was to ensure that Mr C was actually seen for an FSA urgently, at least within six months (which he clearly needed to be, given his "urgent" status), and that he was given priority over relatively less urgent patients. This did not happen.

In his discussion paper on "Aspects of a Doctor's Duty of Care", Dr Geddis accurately summarises a specialist's responsibility in prioritising referrals, as follows:⁴

"A consultant currently makes choices regarding which referrals are seen and to whom treatment is offered and, given that a doctor's duty of care encompasses a requirement to use their skill and judgment, it is obvious that these attributes must be applied to the way in which such priorities are determined.

Therefore to the best of one's ability there is a duty to ensure that: only those referrals that can be seen within the resources available are accepted; referrals are seen in order of priority; patients are assessed in a way that enables a decision to be made as to their priority for treatment as against that of other patients; and patients receive treatment in accordance with their assigned priority. The process of prioritization incorporates the integration of both objective information and clinical judgment.

² *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 at pp 556–557, per Reynolds JA.

³ Geddis, D, "Aspects of a Doctor's Duty of Care", *Discussion Document* (Ministry of Health, updated 15 February 2005).

⁴ *Ibid*, page 17.

...

It is unwise for a doctor to attempt to deny the reality of the situation when it is apparent that not everyone can be seen in a timely manner. Allocating the same priority to every patient for a first specialist appointment will lead to some patient suffering detrimental consequences through a failure of the consultant to ‘*exercise reasonable care and skill*’.”

The Medical Council spells out its expectations of specialists dealing with outpatient referrals as follows:⁵

“...

17. As far as possible assessment should fairly establish the patient’s priority for treatment compared to that of other patients. For example, a doctor working in both public and private practice should only be able to shift patients from his or her private practice to the public system if those patients are subject to the same priority assessment criteria and are not seen before more needy patients in the public booking system.
18. Doctors have a responsibility to ensure that the process for assigning priority is appropriate. Referrals to a service with limited resources should be seen in order of priority and a patient should receive treatment in accordance with his or her assigned priority. Prioritisation systems should be fair, systematic, consistent, evidence-based and transparent.”

Dr D did not fulfil his responsibilities in relation to prioritisation. He simply added Mr C to the ever-growing list of patients awaiting FSA. Dr D’s high level of assigning patients to “urgent” meant that he was not adequately differentiating between patients in this group. This resulted in Mr C not being given the real priority for FSA that his condition warranted. Had Dr D given Mr C an FSA based on his priority relative to others, he would not have been left in limbo waiting over 22 months for an FSA. In these circumstances, Dr D breached Right 4(1) of the Code.

Provision of information

Right 6(1)(c) of the Code provides that every patient has the right to be told of the estimated time within which services will be provided.

In his letter of 25 September 2002, Dr D advised Mr C and Dr A that Mr C had been placed on the urgent waiting list and would be seen when “his turn comes up”, which was unlikely to be for “several months”. Given the number of patients he was prioritising as urgent, Dr D must have known that he could not see Mr C for his FSA

⁵ Medical Council of New Zealand, *Statement on safe practice in an environment of resource limitation* (Wellington, October 2005).

within six months, yet Dr D did not clearly convey this in his letter of 25 September 2002. Had he done so, Dr A might have been alerted to follow up on the referral after six months or to recommend that Mr C consider private treatment.

As noted above, it is the DHB that bore primary responsibility for ensuring that Mr C and his GP were given clarity about when they could expect Mr C to be seen for FSA, and that they received information on waiting times. However, in this case Dr D took it upon himself to provide Mr C with information about the estimated time within which services would be provided. In so doing, Dr D had a responsibility to provide Mr C with an accurate estimate, based on his knowledge of realistic waiting times. Dr D must have known that Mr C would not be seen within six months. Dr D should have provided Mr C and his GP with accurate information about the expected waiting time. His failure to do so is a breach of Right 6(1)(c) of the Code.

Southland District Health Board

Service specification

Under the Ministry of Health national service specification, SDHB had a duty to develop, implement and manage booking systems for all medical, surgical and diagnostic services. If SDHB could not meet the ongoing demand for specialist assistance and advice within six months of referral, the specification required SDHB to prioritise referrals, notify referrers and patients of the ability or inability to provide services within the minimum standard of six months, and provide referrers with information that indicated the level of need or priority that could be serviced, together with referral or management guidelines to enable general practice to manage the patient's plan of care and review or reassess the patient's condition as appropriate. In my view, SDHB failed to fulfil its duty to Mr C, for the reasons set out below.

Provision of information

To meet its obligation, SDHB needed to have in place systems and procedures to monitor and review FSA waiting lists and referrals back to general practitioners for ongoing monitoring. This should have included a "bring-up" or "flag" alert to staff when referrals were not been met within the specified time frame, to assist the DHB to meet its service specification requirement to notify the patient and referrer of possible delays in the provision of treatment.

Dr Nixon, advisor to ACC, noted that in most outpatient clinics in New Zealand, correspondence will be sent to a patient and/or the patient's GP if the patient has been waiting more than six months for an appointment. The correspondence usually includes suggestions for management, and the GP is asked to review the patient to ensure that the patient's symptoms have not worsened.

In my view, a DHB is subject to the following obligation to provide information, derived from the national service specification and affirmed by the Code. If the number of patients to be seen for FSA outnumbers the resources available, it is the DHB's responsibility to advise the patient and the referring GP that based on the

patient's current condition (as reported in the referral letter) *either* the patient will be seen for FSA within six months *or* the service is unable to see the patient for FSA within six months (with an explanation of the reason for the inability to provide services). The patient and the GP should be given clear and specific advice about the option of seeking private assessment and treatment. The GP should be given any other information that would be helpful in managing the patient. The GP should be told to re-refer the patient if his or her condition deteriorates, or there is further relevant information that would affect the patient's priority and was not included in the original referral letter.

None of this information was sent to Mr C or his GP in the 22-month period while he waited to be allocated an FSA at Southland Hospital. He was left to languish on the waiting list, and received no explanation for the lengthy delay. SDHB's total failure to provide Mr C or his GP with the required information constitutes a breach of Right 6(1) of the Code.

Management of FSA list to ensure the provision of timely treatment to Mr C

SDHB was aware, or should have been aware, that Dr D was categorising over 50% of his patients on the "urgent" FSA list and that his rate of seeing new patients was substantially lower than other DHBs in New Zealand. SDHB must have been aware that Dr D's practice was affecting its ability to meet its obligations under the national service specification, including timely treatment for patients such as Mr C.

I endorse the Medical Council's statement that "prioritisation systems should be fair, systematic, consistent, evidence-based and transparent".⁶ It was unacceptable for SDHB management simply to "track the trends and statistics", responding to individual cases such as Mr C's only on receipt of a complaint (see Dr F's advice, quoted at page 9). District Health Boards cannot stand by passively while patients are denied timely treatment. Clearly, the system in the Southland Hospital Urology Department for review of patients waiting for an FSA was woefully inadequate.

SDHB did attempt to address the issue of the ever-lengthening FSA urology list with Dr D, but it failed to find a solution. This meant that the status quo continued for far too long, during which time patient safety was put at risk. As noted by Dr Nixon, "it is hard to understand how a patient with an urgent prioritisation could not be seen".

I agree that it was appropriate for SDHB to focus on long-term solutions, but to do so at the expense of addressing the immediate problems was unacceptable. SDHB needed to address the immediate waiting list, as well as develop a long-term, sustainable plan. This is what SDHB eventually did — addressing the immediate

⁶ Medical Council of New Zealand, *Statement on safe practice in an environment of resource limitation* (Wellington, October 2005), para 18. Although the Council's statement is directed to medical practitioners, the quoted passage is relevant and applicable to DHB prioritisation systems.

problem through the super clinic in November 2004 and the long-term issue through the appointment of a urology nurse to monitor and manage the FSA waiting list. The main reason why this action did not take place at an earlier stage appears to be the intractable relationship that existed between Dr D and the Board. To allow that difficult relationship to interfere with its duty to appropriately manage and monitor the FSA list was a dereliction of duty, and clearly contributed to the failure to provide Mr C with timely treatment following Dr D's urgent referral for an FSA.

In these circumstances, the Board breached its duty of care under Right 4(1) of the Code.

Dr D and Southland District Health Board

Co-operation and co-ordination of care

While there is a clear division of responsibility in the management of patients waiting for specialist assessment in the public system, it is essential that the DHB, the specialist and the GP work together to ensure quality and continuity of care for patients.

In my view, both SDHB and Dr D failed Mr C. If a patient's service providers do not work together to ensure that patients waiting for assessment and treatment are adequately informed and managed, it is inevitable that some patients will fall through the cracks, compromising their patient's care. This is what happened to Mr C. District Health Boards have an obligation to put systems and procedures in place to ensure an adequate and effective system for managing waiting lists for FSA appointments, under which patients are kept informed of their status and options. Individual clinicians have an obligation to work with the DHB to appropriately prioritise and offer appointments on the basis of priority. In this case, Dr D and the SDHB failed to work together effectively and Mr C was left waiting in limbo. He did not receive quality and continuity of care. In these circumstances, Dr D and SDHB breached Right 4(5) of the Code.

DHB employment disputes about clinician behavioural issues

In a separate investigation relating to Dr D's management of a patient with bladder cancer (04HDC11624, 4 April 2006), I made the following comments that are also relevant to this case:

“I recognise the difficulties that DHBs face when the concerns about a clinician's practice primarily involve behavioural issues. I also acknowledge that not following due process when imposing disciplinary action can expose the employer to a personal grievance claim. However, a DHB's first duty must always be to safeguard its patients. Behavioural issues, no less than clinical competence concerns, can place patients at risk and must be addressed. I am confident that the

Employment Court would take account of a DHB's responsibility to its patients. As noted by Judge Finnigan in *Air New Zealand Ltd v Samu* [1994] 1 ERNZ 93 at p 95, "[W]here safety is genuinely involved in the operations of an employer it is not just another ingredient in the mix, another factor to be taken into account. Safety issues have a status of their own."⁷

Other comment

GP care

As noted earlier, Mr C's GP owed Mr C a duty of care for his clinical day-to-day management pending the allocation of an FSA appointment at Southland Hospital. Mr C is loyal to his GP and specifically did not want him included in this investigation. However, I am concerned that Dr A did not fully meet his obligations to Mr C in this case.

Under Right 6(1) of the Code, Mr C had the right to more information than simply when he was likely to receive an FSA. He had the right to be told about what other options were available to him, such as the right to seek private assessment and treatment if publicly funded services were not available. He had the right to be told what an elevated PSA meant and to be informed of the risks of not being seen "urgently". Mr C did not contact the hospital in the 22 months he waited for an appointment because he had no idea that anything was wrong with him. It was Dr A's responsibility, as Mr C's GP and the only clinician in direct contact with him, to provide the information he needed to know.

While Dr A continued to monitor Mr C through PSA tests, and forwarded the results to the Urology Clinic (although the clinic has no record of receiving the test results), he did not take any steps to actively follow up his referral and Mr C's status on the waiting list. Dr A should have provided this information. I acknowledge the difficult relationship between the local GPs and the urology service, and Dr A's concern that Mr C would be disadvantaged if he did personally follow up the referral. That does not absolve Dr A of responsibility. Knowing Mr C's continued high PSA and the lack of contact from Southland Hospital, Dr A should have done more. He should have taken steps to follow up his original referral in June 2002, either through further written correspondence or by telephone. This would have been consistent with good quality general practice care.

⁷ The decision was affirmed by the Court of Appeal in *Samu v Air New Zealand Ltd* [1995] 1 ERNZ 636 (CA).

Recommendations

- I recommend that Dr D apologise in writing to Mr C for breaching the Code. The apology is to be sent to this Office and will be forwarded to Mr C.
 - I recommend that Southland District Health Board apologise in writing to Mr C for breaching the Code. The apology is to be sent to this Office and will be forwarded to Mr C.
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Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, the Minister of Health, the Director-General of Health, the Royal Australasian College of Surgeons, and the Royal New Zealand College of General Practitioners.
- A copy of this report, with details identifying the parties removed (other than Southland District Health Board and Southland Hospital), will be sent to the New Zealand Medical Association, the Association of Salaried Medical Specialists, and all District Health Boards, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.