Emergency Medicine Practitioner / Crown Health Enterprise

Report on Opinion - Case 97HDC7550

Complaint

The Commissioner received a complaint from a consumer about a doctor. The complaint was that:

- *The doctor kept her at a public hospital for 12 hours rather than sending her immediately to another public hospital for a MRI scan and surgery.*
- *This delay destroyed any hope the consumer had of walking again.*

Investigation

The complaint was received on 16 July 1997 and an investigation undertaken.

Information was obtained from:

- The Consumer
- The provider/Doctor
- Orthopaedic Surgeon
- Duty House Officer
- Customer Services Co-ordinator, Crown Health Enterprise
- Chief Executive Officer, Crown Health Enterprise

The consumer's clinical notes were obtained and considered.

The Commissioner obtained advice from an emergency medicine practitioner.

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Outcome of Investigation

The consumer was transported to the public hospital's emergency department by ambulance on a date in late April 1997. The provider was the doctor on duty who saw her there and the senior emergency medicine doctor on duty.

When she arrived at 11.55pm, she was triaged by the emergency nurse as level 3 – that is semi-urgent – must be medically assessed within 30 minutes. The nurse recorded her history as follows:

> *"Lower back pain tonight (suffers chronic pain → result of fall 5 years ago). Right leg numb, unable to move, reduced sensation in both limbs".*

Her blood pressure was recorded as 140/80 and her pulse rate 76 beats per minute. Past medical history was noted as being positive for Pagets disease of the breast resulting in a mastectomy in 1996. Her only medications were oral panadol.

The time that the consumer was first seen by the provider is not recorded but she received intravenous narcotic medication at 12.10am as ordered by the provider. The provider recalls seeing the consumer "*around midnight".* The provider recorded a history of severe lower lumbar backache associated with pain in the lateral left thigh. He also recorded that the consumer suffers severe back pain – but this was worse than usual. On examination he noted that she was *"in pain on movement".* Her abdominal examination was normal. On musculoskeletal examination he noted:

> "*Very tender Lumbar 4-5. Unable to move right leg. Power in right leg 0/5 from hip flexors to toes! Left leg power 4/5 with dorsi/plantar flexion left foot. Reflexes unilaterally decreased. Sensation - ? , seems to have altered sensation to pinprick from right groin to toes and in the left from the mid-thigh to toes. S.L.R. Left = right = 70° → no significant pain. Anal tone ok. Impression: ? Prolapsed lumbar disc ? Secondary to cancer → X-ray lumbar spine → NAD (no applicable disorder).*"

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Outcome of Investigation, *continued*

The provider queried prolapse of a lumbar disc and arranged for an x-ray of the consumer's lumbar spine. The provider reviewed the x-rays at about 0100 the next day, and concluded that they were *"negative"*. The provider decided to observe the consumer and see if she responded to treatment – pain relief and anti-inflammatory medication. Around 0700 The provider was told that the consumer's condition had deteriorated. The provider noted:

> *"Now has paralysis both legs! Anal tone still ok. Sensation equivocal to Lumbar 1, distinct both legs, reflexes ↓↓ ".*

The provider reviewed the consumer at 0700 at which time she had loss of power in both lower limbs with normal sphincter tone. The medical registrar was examining the consumer while the duty house officer was receiving hand-over from the provider. Urgent referral to the orthopaedic registrar was recommended. The provider's shift ended at 8am.

At 0900 the duty house officer, who had taken over from the provider, requested referral to the orthopaedic registrar at another public hospital: *"? Cauda Equina syndrome."*

The duty house officer recalled that on telephoning the other hospital, the operator had difficulty locating the orthopedic registrar and after ten minutes on the phone, the duty house officer was connected to the senior orthopaedic registrar and spoke with him from 8.55am to 9.00am. The duty house officer arranged an urgent MRI at the hospital and was to transfer the consumer once the MRI was completed. The duty house officer phoned the radiology registrar at the second hospital, who informed the duty house officer that the MRI must be arranged via the region's radiology group.

At this time, the duty house officer was asked to review another of the overnight patients and ten minutes later, the duty house officer returned to continue arrangements for the consumer's MRI. The duty house officer said she rang the region's radiology group answering service and obtained the home number for the neuroradiologist on-call. He approved the MRI and the duty house officer was given the number for the neuroradiographer, with whom arrangements were made for her to be available as soon as the consumer could be transferred to the second hospital's MRI.

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Outcome of Investigation, *continued*

At 9.55 the duty house officer said she asked the nursing staff to call an ambulance explaining that this was a surgical emergency and it was maximum priority to have the consumer transferred immediately. The call was made to the ambulance control office at 9.56 am and a further call was made thirty minutes later when the ambulance had not arrived. The duty house officer made a further call at 10.44am and was informed that the ambulance had arrived in the ambulance bay. The ambulance left the hospital at 11.04am.

The duty house officer said that prior to the consumer being transferred, the consumer's husband and daughter had asked her to explain the consumer's diagnosis and management plan. The duty house officer said she explained that the consumer had compression of the spinal cord and that there were two main possibilities. These were that she may have suffered a prolapsed disc which was compressing the spinal cord and the other possibility was that in view of her diagnosis of breast carcinoma one year ago, there could be a metastasis compressing the spinal cord. The duty house officer explained that a MRI would assist in determining the cause of the compression and management would depend on the result of the MRI.

The x-ray of the lumbar spine, which had been performed by the first hospital and interpreted as normal by the provider, was reported at the second hospital by two doctors. The report reads:

> *"There is a loss of disc height at T11/12 which has been subsequently noted as disc prolapse on MR. No focal bone lesion nor destruction is identified."*

The MRI scan showed that a thoracic disc had prolapsed causing around 75% spinal canal compromise.

The day after being admitted, the consumer had a right T11 costotransversectomy and T11/12 disectomy at the second hospital. The operation note records:

> "*This 63 year old lady developed acute right leg pain about 5pm last night. At about 7pm she went upstairs to bed and had great difficulty getting up the stairs due to pain. At 9pm her right leg became paralysed. She went into* [the first hospital] *by ambulance where slowly her left leg became paralyzed and she had no feeling essentially from her waist down.*"

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Outcome of Investigation, *continued*

The note further indicates:

> *"At the time of surgery she was found to have a large posterior osteophyte compromising the canal and I* [orthopedic surgeon] *suspect that she had a small soft disc prolapse which caused her onset of paraplegia".*

The consumer was transferred from the second hospital to the spinal unit on the next day.

The consumer is now at home and is paralysed in both legs.

The provider confirms that he reviewed the consumer in the first hospital's emergency department, with complaints of *"...severe lower lumbar backache, inability to move the right leg and weakness of the left leg".* He also noted that *"...the particular backache that she was suffering was chronic and secondary to a fall some 5 years previously, however the pain had suddenly increased."*

He further writes:

> *"I considered that she may have had a secondary cancer in the spine from the previous cancer of the breast".*

On arranging x-rays, he noted that the x-ray was *"negative"* and that he *"...decided to observe her and see how she responded to treatment, as I felt that the decreased movement may have been secondary to pain, and that a problem in the lower lumbar area, where she was tender and having pain, should not cause weakness of the hip flexors (i.e. paraplegia)".*

He further indicates that he was *"...extremely surprised to learn of her diagnosis and that…. Subsequent reading discovered that the incidence of this condition is approximately 1 per million population per year".* The provider included evidence of such incidence by a copy of pages of a textbook.

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Outcome of Investigation, *continued*

The provider is a fellow of one of the Royal College of Surgeons and the acting clinical director of the emergency department at the hospital. The provider, in his response to my provisional opinion, advised that on the night in question he had been on duty for ten hours without a break and had treated twenty significantly ill patients.

The orthopaedic surgeon, as part of the investigation, was asked whether an earlier transfer to the second hospital would have improved the outcome. The orthopaedic surgeon responded:

> *"If the patient had been transferred to* [the second hospital] *at midnight on* [the date the consumer was admitted], *there would have been a delay in the order of four or five hours minimum before she would have been able to get to an operating theatre. As seen above, by 0700 hours the next morning she was essentially paraplegic. Thus her paraplegia progressed over the period of the early hours of the morning of* [the next day].
>
> *In the circumstances of the patient's late presentation to the* [first hospital] *on* [the date of her admission] *and her subsequent progression of neurological deficit over the next few hours, it is my opinion that earlier transfer to* [the second hospital] *would not have prevented the rapid onset of her paraplegia.*
>
> *Unfortunately once the paraplegia was established, due to the level and nature of the lesion causing her paraplegia, it was unlikely that she would recover despite decompression."*

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Report on Opinion Case 97HDC7550, continued

Response to Provisional Opinion

The Provider

In response to the Commissioner's provisional opinion, the provider explained that he was the only doctor on duty responsible for patients presenting to the emergency department on the night in question.

> *"I worked 10 hours without a break and treated some twenty significantly ill patients".*

The provider provided a list of patients that presented to the emergency department that night and my emergency medicine advisor reviewed that list and confirmed that:

> *"The major problem here was a sole senior doctor attempting to accommodate an unusually large volume and intensity of patient presentations on a weekend graveyard shift. This has been shown to be an impossible task".*

The provider, in both his reply to the Commissioner and apology to the consumer, noted that he now appreciates he was unable to provide the standard of care required due to these logistical problems. His solution as acting director of the emergency department has been to improve the overnight staffing levels of doctors in the emergency department and keep management informed.

Crown Health Enterprise

The Chief Executive Officer ("CEO") of the Crown Health Enterprise informed the Commissioner that on the night the consumer was admitted to the hospital, the staffing levels were one senior doctor and three registered nurses.

The CEO attributed the staffing levels to funding constraints and advised that since September 1997, regardless of funding constraints, the emergency department has increased the staffing levels to four registered nurses on Thursday, Friday and Saturday nights (while the other nights remain at three), to relieve the pressure on the doctor.

At the beginning of 1999, the emergency department increased the overnight staffing levels to one senior doctor, one junior doctor and five registered nurses on Thursday, Friday and Saturday, and four registered nurses on Monday, Tuesday, Wednesday and Sunday.

The CEO also advised the Commissioner that the Crown Health Enterprise has implemented a 24 hour, 7 day week, CT scanning facility since the beginning of 1998 and no longer has to rely on the second hospital's radiology for CT scanning.

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Report on Opinion – Case 97HDC7550, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

4) 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.

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

Clause 3 Provider compliance

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

2) The onus is on the provider to prove that it took reasonable actions.

3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

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Report on Opinion – Case 97HDC7550, continued

Opinion: Breach – the Provider

In my opinion the provider breached Rights 4(2) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

In my opinion the provider failed to provide the level of care owed to the consumer with regard to his assessment, his history and physical review, and his therapeutic plan. My advisor noted:

"1. The written history fails to outline:

a) the presenting complaint, that is, 'back pain with loss of movement in her right leg and weakness in her left leg';

b) the chronological sequence of events of [the consumer's] *presenting complaint, i.e. development of back pain around 5 PM , difficulty walking up stairs to bedroom, loss of movement in the right leg precipitating presentation via ambulance to* [the first hospital]*;*

c) an analysis (synthesis) of the differential possibilities as to the causation of her complaint including the recent history of breast cancer.

2. The recorded physical examination fails to outline an appropriate general examination – some mention of breath sounds, pupil responses, speech etc as well as cardiac exam.

3. The musculoskeletal examination should have included a review of the whole of the dorsal and lumbar spine.

4. The neurological examination should have included sensory and motor testing above the lumbar area; i.e. abdominal & cremasteric reflexes; pinprick and sensation above the groin.

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Opinion: Breach - the Provider, *continued*

5. *The synthesis of the history and physical examination should have been recorded – this would require some indication of the past history of back pain, the severity and episodic nature of this pain, the patient's opinion with regard to the cause (i.e. a fall), the progressive loss of function on the day of presentation and the potential possibilities, a working diagnosis and a therapeutic plan. If such an approach had been followed, the analysis may have led to a working diagnosis of spinal compression (rapidly progressive) possibly secondary to metastatic disease, vascular insult or disk herniation.*

6. *There is no recorded 'plan for action or observation'.* [The provider] *has put in a number of queries related to ? prolapsed lumbar disk and ? Secondary cancer, undertook a plain lumbar x-ray but has not specified any further plan of action. There is no record that the unit nursing staff have been requested, for example, to monitor the patient's signs or symptoms from a neurological perspective.*

If [the provider] *had provided the care and level of skill required by a senior doctor in Emergency Medicine in a New Zealand Public Hospital, he would have indicated a number of facts in his record – some of these he put in his letter based on his recall of the patient following the Health & Disability Commissioner's enquiry.*

The last paragraph on page one of his letter, dated [mid-October 1997]*, states:*

> *'She returned from x-ray at approximately 1.00 am when I reviewed the x-rays. The x-rays were negative, and I decided to observe her and see how she responded to treatment, as I felt that the decreased movement may have been secondary to pain, and that a problem in the lower lumbar area, where she was tender and having pain, should not cause weakness of the hip flexors (i.e. paraplegia).'*

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Opinion: Breach - the Provider *continued*

In this paragraph, he unbundles some first-degree errors in his assessment – particularly his finding that her problem was secondary to a ? Disc herniation/ ? Metastasis in the lumbar area – this led to his narrow interpretation of the x-ray. Indeed, the x-ray did show a negative exam of the lumbar vertebrae. If he had followed first principles, he would have looked discerningly at the whole of the spine—would have presumably seen the narrowing of the disc height at T11/12 and most likely would have returned to the patient and re-examined her."

In his letter dated mid-October 1997, the provider stated that he felt the consumer's loss of movement may have been a consequence of pain. My advisor noted:

"This is not supported by his recorded examination which notes zero power from hip flexors to toes on the left, reduced reflexes and reduced sensation. It is also not supported by his subsequent actions as he made no effort to review her following the delivery of appropriate pain relief. If such an examination had taken place he would have noted that she continued to be incapable of moving the leg and that if anything, her signs were progressing. He may even, have reviewed his working diagnosis of a lumbar location of her problem."

In my opinion, the provider did not obtain and adequately record the consumer's history nor did he undertake appropriate examinations and record options to be taken.

I note the advice received that it was unlikely that earlier treatment would have resulted in an improved outcome. In reaching this opinion, I have considered the actions taken and not the outcome.

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Report on Opinion Case 97HDC7550, continued

Opinion: Breach - the Provider *continued*

Right 4(5)

The provider did not set out a treatment plan to guide the nursing staff in caring for the consumer. The advisor noted:

> "*He did not record his 'opinion', his 'plan of action' or provide the nursing staff with any guidance as to what they should be doing with the patient over and above relieving her pain"*.

In not doing so, the provider failed to establish a basis for co-operation so the nurses could ensure quality services.

Clause 3

While I have identified areas in which the provider did not provide services that met appropriate standards, I must also consider whether his actions were reasonable in the circumstances in light of the staffing situation that existed at the hospital at the time. The provider was placed in a situation in which he was the sole doctor responsible for the complete care of all of the patients presenting that night – a total of 22 patients of whom the intensity of care required was a minimum of 108 minutes for at least 12 of these patients.

My advisor confirmed that it was impossible for any single doctor, no matter how senior, to provide the required standard of care for the number of patients presenting that night. I therefore considered whether the provider was unable to provide the consumer with the care she required because of the resourcing constraints the provider was expected to work under.

While I accept the provider's comments regarding the difficulty in staffing and the advice of my expert, the provider provided no information that he took action to bring this matter to the attention of his employer, the Crown Health Enterprise.

While the staffing numbers meant the provider was unable to meet appropriate standards, this did not remove his obligation to take reasonable steps. As acting clinical director, he had a duty to inform the Crown Health Enterprise of the staffing difficulties in order to meet his duty of care.

Emergency Medicine Practitioner / Crown Health Enterprise

Report on Opinion – Case 97HDC7550, continued

Opinion: Breach – the Crown Health Enterprise

In my opinion, the Crown Health Enterprise breached Right 4(4) of the Code of the Health and Disability Services.

When the consumer presented to the emergency department of the hospital, it was reasonable for her to expect that the staff there would be able to provide her with the emergency services she required. The Crown Health Enterprise was contracted to provide emergency services to consumers. The Crown Health Enterprise has attributed the staffing levels to funding constraints and I accept that. The staffing levels in place at the hospital did not enable the Crown Health Enterprise to provide the consumer with the services she needed. The Crown Health Enterprise has not provided any evidence that at the time the consumer presented to the hospital, the Regional Health Authority had been advised they would be unable to provide services of an appropriate standard based on the funding received. In the absence of any documented evidence that this was the case, in my opinion it was not reasonable that the hospital's emergency department was under staffed.

In my opinion, the Crown Health Enterprise breached the Code of Health and Disability Services Consumers' Rights by not ensuring that the emergency department at the Hospital was adequately staffed to a level that would ensure the consumer was provided with a service that met her needs.

Actions: the Provider

The provider has apologised to the consumer and undertaken to ensure he records appropriate patient history and prepares treatment plans, including observations required, for other staff to follow.

The provider has also brought to the Crown Health Enterprise's attention the number of patients presenting at night resulting in an increase in the staffing of doctors and nurses in the emergency department.

The provider has undertaken to read the Code of Health and Disability Services Consumers' Rights.

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Report on Opinion – Case 97HDC7550, continued

Actions: The Crown Health Enterprise

The Crown Health Enterprise has gradually increased the staff numbers to meet the needs of consumers presenting at night.

At the time of this incident there was one senior emergency doctor and three nurses on night shift. In September 1997, staffing numbers on Thursday, Friday and Saturday was increased to four numbers. In January 1998, night staffing increased to one senior doctor, one junior doctor and four nurses, with a further increase to five nurses on Thursday, Friday and Saturday nights.

Actions: Health Funding Authority

I suggest the Health Funding Authority review the contract with the Crown Health Enterprise to ensure it is funded appropriately to provide emergency services to the region in accordance with national policy.

Other Actions

A copy of this opinion will be sent to the Minister of Health and the Director General of Health to being to their attention the continuing issues the quality of public hospital emergency services and remind them of my recommendations set down in the Canterbury Health Report.

In particular:

Ministry of Health

- Commences a review of current standards and quality processes in every public hospital in New Zealand using an accredited quality agency. The purpose will be to ascertain the comparative levels of quality policies, and quality control, in different hospitals. The aim over time must be to ensure that consistent standards of care are applied and that all hospitals comply with standard risk management techniques.
- Works with the Crown Company Monitoring Advisory Unit to facilitate the relationship between purchasing and provision of services and, where necessary, to appoint in conjunction with Crown Company Monitoring Advisory Unit, independent arbitrators to resolve contractual issues. This will ensure that contracts are concluded effectively and that sound commercial principles are applied in negotiating prices and volumes.

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Report on Opinion – Case 97HDC7550, continued

Other Actions, *continued*

Health Funding Authority

- Examines the funding arrangements for emergency departments in public hospitals.
- Reassesses its purchasing priorities, to ensure the Health Funding Authority purchases the necessary volumes of emergency services.

A copy of my opinion will be sent to the President of the New Zealand Medical Council, to the Health Funding Authority and the Crown Company Monitoring Advisory Unit.