Nelson Marlborough District Health Board

A Report by the

Health and Disability Commissioner

Case 09HDC00891

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

It is well recognised that there is insufficient public funding to meet the immediate health needs of all New Zealanders, and that some patients who require elective services are unable to access them through the public system. Public hospitals are expected to treat those with the greatest need first. In this environment, it is essential that patients are treated fairly, consistently, and to an appropriate standard within the resources available.[1]

This case examines the prioritisation and management of a patient, Mrs A, a young woman in her mid-twenties, who was waiting for ENT and radiology services from Nelson Marlborough District Health Board (NMDHB). Mrs A experienced symptoms that were recognised as serious by her GP and a private ENT specialist, but were not considered urgent enough by NMDHB to warrant a publicly funded MRI scan. She was subsequently diagnosed with a brain tumour, part of which has been removed.

This case highlights the need for clarity and timeliness of information about assessment and treatment options, if publicly funded services are not available. It also illustrates the unfairness of "postcode lottery" access — where the ability to access publicly funded services depends on the patient's place of residence in New Zealand.

Complaint and investigation

On 13 February 2009 the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by Nelson Marlborough District Health Board. The following issue was identified for investigation:

- *The appropriateness of the care and adequacy of the information provided to Mrs A by Nelson Marlborough District Health Board between 2006 and 2008, including the adequacy of the actions taken by Nelson Marlborough District Health Board to ensure that Mrs A received timely services following referrals for a specialist appointment and MRI scan.*

An investigation was commenced on 12 March 2009.

The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Dr B	Otolaryngologist
Dr C	General practitioner
Nelson Marlborough DHB	Provider

[1] A Guide to Elective Services at Public Hospitals, Ministry of Health, 2007. Available at: www.moh.govt.nz/electiveservices.

Also mentioned in this report:

Dr D	Otolaryngologist
Dr E	Radiologist

Otolaryngology advice was obtained from Dr Catherine Ferguson (appendices 1 and 3) and radiology advice was obtained from Dr Jean Murdoch (appendix 2). As part of its response, NMDHB submitted expert advice from Dr Sharyn MacDonald (a radiologist) which is attached as appendix 4.

Information gathered during investigation

Mrs A, a young woman in her mid-twenties, consulted her general practitioner, Dr C, about her hearing difficulties and right ear pain in 2005. Dr C referred her for audiology testing. On 10 November 2005 Mrs A received an audiological examination from an audiologist at Wairau Hospital. The audiologist recommended that Mrs A see an ENT specialist.

Specialist referral — February 2006
On 5 February 2006 Dr C referred Mrs A to the ENT department at Wairau Hospital for further assessment. The letter of referral stated:

> "Please arrange an appointment to see [Mrs A] for assessment regarding tinnitus in the right ear and mild sensorineural hearing loss. She has noted a 'buzzing' in her right ear and mildly decreased hearing in this ear for several years. She was referred for audiological testing which has shown a mild sensorineural loss which is worse in the right ear. … The audiologist suggested referral in view of the asymmetry of [Mrs A's] hearing loss. Your assessment and advice would be appreciated."

The referral was received at the ENT department on 7 February 2006 and prioritised as "6/12 +" on 10 February 2006. NMDHB considered that Mrs A's referral was non-urgent — over six months to see a specialist — as her symptoms were unilateral hearing loss and tinnitus with no neurological findings.

In 2006 NMDHB was unable to see all patients referred to the ENT department within six months. One of the ENT specialists had a leave of absence and then resigned, and the DHB was unable to recruit a replacement for some time.

In a letter dated 14 February 2006, the ENT department, Wairau Hospital, advised Mrs A and Dr C that an outpatient appointment could not be provided in light of her "routine" priority. The letter noted:

> "We have received a referral for you to the ENT Department. This has been assessed and graded with a routine priority. Nelson Marlborough District Health Board endeavours to treat patients according to their needs, and patients with urgent or life-threatening conditions remain our first priority.
>
> …
>
> We recommend that you consult your General Practitioner (GP) if your condition becomes worse. Your GP may then notify us …"[2]

Private specialist referral — November 2006

On 10 November 2006 Mrs A saw her general practitioner in relation to her longstanding hearing symptoms and more recent symptoms of vertigo/balance loss. Dr C referred her to the ENT surgeons, Drs B and D, for a private assessment. The letter of referral dated 11 November 2006 noted:

> "[Mrs A] has noted a 'buzzing' in her right ear and mildly decreased hearing in this ear for several years. She was referred for audiological testing which showed a mild sensorineural loss which is worse in the right ear. In view of the asymmetry in the hearing loss I referred [Mrs A] to the ENT outpatients clinic at Wairau but she did not meet the criteria to be seen.
>
> [Mrs A] consulted me recently with a history of recent episodes of vertigo and a feeling of loss of balance associated with sudden head movements …"

On 4 December 2006 Mrs A consulted Dr B, otolaryngologist, at his private clinic.[3] Dr B recommended an MRI brain scan and offered to follow her up through the public hospital system.[4]

On 4 December, Dr B reported his assessment to Dr C, and copied it to Otolaryngology Secretaries at Nelson Hospital, NMDHB. He reported that Mrs A "had been troubled by a 3 year history of persistent right sided tinnitus" and mild right-sided hearing loss. Over the "last 11 months she has been troubled by intermittent episodes of rotary vertigo … The sever rotation lasts for between 15–20 seconds and she feels slightly nauseous afterwards. At present she is getting 2–3 attacks per week." Dr B reported that she had healthy tympanic membranes.

---

[2] A GP protocol was subsequently issued because the ENT department was unable to see low priority patients. From March 2006 it was standard practice to include the protocol with the letter to the GP declining service.

[3] Dr B practises at the ENT department at Wairau Hospital and sees private patients.

[4] The preferred initial screening modality for diagnosing vestibular schwannoma is magnetic resonance imaging. The consensus is that patients with an asymmetric sensorineural hearing loss, a sudden sensorineural hearing loss or a longstanding unexplained asymmetric sensorineural hearing loss warrant screening to exclude a vestibular schwannoma, as well as patients with unexplained tinnitus, Ménière's symptom triad, and a family history of neurofibromatosis type two: Dawes P, "Screening for vestibular schwannoma: Current practice in New Zealand". *Australian Journal of Oto-Laryngology*, July 1999.

MRI referral — December 2006
That same day, 4 December, Dr B sent an MRI referral form and a letter to Otolaryngology Secretaries, Nelson Hospital, requesting that an MRI scan be arranged for Mrs A through the public hospital.

The MRI referral form notes the clinical details as "unilateral R tinnitus, hearing loss, paroxysmal rotatory vertigo". The form includes a place to grade the priority of the MRI referral, the options being urgent, semi-urgent or routine. Dr B checked the "semi-urgent" box.

MRI scanning service
Historically, Nelson–Marlborough patients requiring MRI scanning were referred out of the district as Nelson did not have an MRI scanner. Patients with asymmetric sensorineural hearing loss (ASNHL) were referred to Christchurch or Wellington for MRI scanning. However, by January 2007 a scanner had been installed in Nelson. The MRI service was operated jointly by the DHB and Nelson Radiology. At the time, the scanner was performing three public sessions per week and three private sessions.

Surge of referrals
By February 2007, it was evident that referrals for MRI scans were exceeding capacity. Although the DHB had anticipated that there would be an increase in demand for the service through reducing the travel barriers and the expected take-up in the technology, the rate of demand had increased well above expectations. There were about 160 patients on the public waiting list and, with the rate of new referrals, the waiting time increased by around one week based on the current part-time service of three public MRI sessions per week. The MRI management group (MMG) considered that the service should become full time to respond to the new level of demand.

As a result, the MMG made a submission for an increase in the level of funding to meet the demand for MRI scans. However, the DHB decided not to increase the level of funding in light of budgetary restrictions.

The MMG offered to meet with a group of senior clinicians to determine the clinical priorities for MRI scanning, so that referrers would have greater certainty for their patients — rather than a sliding (and increasing) timeframe for routine referrals (at that time estimated at about six months). The aim was to provide justification to management for whether three, four or five sessions per week were required to meet the projected demand for conditions that are deemed "acceptable". Clinicians were asked to generate a list of conditions that would be accepted for scanning.[5] Concerns were raised by clinicians about the threshold and the risks of a "cut off".

By May 2007 NMDHB agreed to fund five public sessions per week. However, this was still insufficient to cope with demand, and further prioritisation was required.

[5] Email from Dr E dated 13 February 2007.

No access to public MRI for routine patients with ASNHL
In response to my provisional opinion, NMDHB explained that "[a]s a result of the above prioritisation, patients with ASNHL no longer had routine access to public MRI. Importantly, patients with ASNHL exhibiting symptoms and signs indicating more urgency have always been accepted. The decision to decline routine referrals was partly based upon the fact that, during this period, referrals of these patients from GPs were also not accepted by the public ENT service. These referrals did not meet the urgency criteria operative in the ENT department at the time. Thus, the prioritisation in radiology was in line with the ENT service."

The ENT department received a batch of declined MRI referral forms from Radiology and advised relevant patients that lower priority referrals for the MRI test would not be seen. It appears that some of the batch of declined MRI referrals from Radiology included routine ASNHL patients who had been assessed by the ENT department, and symptomatic ASNHL patients (contrary to the statement above).

MRI referral declined — May 2007
On 11 May 2007 Dr E, radiologist, on behalf of NMDHB, advised Dr B, Mrs A and her GP that "although your referral was wait-listed for a publicly funded examination, it is now apparent that the demand for more urgent examinations means that in effect your requested examination will not get done. Other appropriate ways of investigation may be available and these alternatives should be reviewed."[6]

NMDHB explained that "the referral was certainly not forgotten nor ignored. Furthermore, it was possible that the surge in referrals may have reflected pent-up demand which might ease and when this did not occur, further steps were needed. It was only in May 2007, after increasing MRI service, and taking account of more urgent referrals, that the conclusion was reached to decline this referral and, accordingly, a letter was sent to [Dr B]."

ENT concerns
The Head of the ENT department, Dr D, raised serious concerns about the decision not to provide MRI scans for these patients, and approached the specialist society for advice and support. The New Zealand Society of Otolaryngology Head and Neck Surgery (NZSOHNS) considered that the DHB was failing to provide the same standard of care that was available to patients in the remainder of the country, and made recommendations for the interim management of these patients. It was felt that Nelson patients were being unfairly disadvantaged. Dr B also raised concerns.

From 2007 to 2009, there was considerable correspondence between the ENT department, the Clinical Advisory Council and management at Nelson Marlborough DHB, the DHB and the Ministry of Health, the Medical Protection Society, and

[6] Nelson Marlborough DHB subsequently advised Mrs A on 20 November 2008 that her referral was assessed as non-urgent (triage 4). The decision was taken that wait listing of triage 4 patients was no longer possible and referrers were told this, and recommended alternative strategies for care.

NZSOHNS about MRI access for Nelson–Marlborough patients with asymmetric hearing loss.

Specialist referral — April 2008
On 1 April 2008 Mrs A again consulted her GP, Dr C, about her condition. Dr C noted in the clinical record that she had been referred for an MRI but had not met the criteria.

Dr C wrote to Dr B, ENT Outpatients at Wairau Hospital, advising that Mrs A had been sent a letter to say that she did not meet the criteria for an MRI scan in the public system and she could not afford to have a private scan. Dr C noted that she was still suffering from the same symptoms and found the tinnitus most annoying. Dr C asked if Dr B could review her in the public system.

The letter of referral has a stamp on it. The stamp has the following categories: T1, T3, T6 and 6+. Dr B appears to have checked the T3 box.

On 17 April 2008, the ENT secretary from the ENT department at Wairau Hospital wrote to Mrs A acknowledging receipt of the referral letter. The letter stated that the referral letter had been reviewed using the government referral criteria, and her appointment rated as semi-urgent. It also advised that it could be up to three to six months before her appointment to see the specialist, and that she should see her family doctor if the problem deteriorated or changed.

Specialist referral — June 2008
By June 2008 Mrs A's condition was deteriorating. On 22 June 2008 she consulted Dr C about her worsening symptoms. Dr C sent a letter of referral dated 22 June 2008 which stated:

> "[Mrs A] has asked me to write to tell you that she feels that her balance is now being affected and that she tends to veer off course when walking. She does not report any other new neurological symptoms and her balance on heel-toe walking and standing on one foot seemed reasonable. I told her I would pass on this information."

The prioritisation of this second referral was undertaken on 16 July 2008. Mrs A was upgraded to T1 — to be seen in one month by Dr B. Mrs A was booked for an appointment at the next available clinic at Wairau Hospital at 10.30am on 20 August 2008.

Specialist review — August 2008
Mrs A was reviewed by Dr B at Wairau Hospital on 20 August 2008. He noted her increasing unsteadiness and imbalance over the last several months, and that more recently she had had a number of falls and a tendency to drift off to the right-hand side when walking. Dr B was very concerned that Mrs A might have a lesion, possibly an acoustic neuroma. He arranged for her to have an urgent MRI scan.

Dr B phoned the radiology service at Nelson Hospital to arrange the scan. He discussed it with one of the radiologists at Nelson Hospital. Dr B noted his concern that she had been declined an MRI scan almost 18 months previously due to constraints.

As a result, Mrs A received a scan on 29 August 2008. It revealed a 4cm right vestibular schwannoma[7] causing compression of her brain stem and early hydrocephalus.[8]

On 5 September 2008 Mrs A was reviewed by another ENT specialist at Nelson Hospital as Dr B was on leave, and then referred to the neurosurgery team in another centre, where she was booked for surgery on 16 September.

On 16 September 2008 Mrs A underwent a right posterior fossa craniectomy for extensive but subtotal removal of her large acoustic neuroma. She has made reasonable progress since her nine-hour surgery, but now has a "dead" right ear as a result of the resection, and experiences headaches. Mrs A underwent further surgery in 2010 in relation to the tumour.

Subsequent action taken by Nelson Marlborough DHB
On 16 October 2008 Mrs A complained to Nelson Marlborough DHB about the delays she had experienced. She asked, "At what stage do NMDHB class people as urgent?" She did not want others to experience what she and her family had suffered.

The DHB responded on 20 November 2008. It explained that it was currently reviewing its MRI service and working with clinical staff to look at solutions to address issues of demand and capacity, including resources that determine the availability of the service. The DHB was also looking to reallocate resources to appoint additional staff, including several radiologists and technicians, and thus increase capacity. It had been able to secure another ENT specialist, so that the ENT service is now able to see more patients. Referrals for ASNHL are again being accepted. The DHB considered that Mrs A's referral was triaged appropriately, based on the information provided and access criteria applicable at the time.[9] Mrs A was not satisfied with the response, and complained to HDC with the support of her ENT specialist, Dr B. A copy of his draft letter to NMDHB was attached.

In August 2009 Nelson Marlborough DHB advised that in line with the recommendations from its Clinical Advisory Council, MRIs will soon be made available for patients with asymmetric hearing loss. The DHB has:

- increased the resources in Radiology (radiologists and MRTs (medical radiation technologists));

[7] A vestibular schwannoma or acoustic neuroma is a benign, slowly growing tumour of the vestibulocochlear nerve. A large vestibular schwannoma can be life-threatening.
[8] Hydrocephalus is the buildup of too much cerebrospinal fluid in the brain.
[9] The DHB was unable to provide HDC with a copy of the applicable criteria or guidelines relied on.

- brought the waitlist for MRIs under control as a result of the increase in resourcing and efficient practice of the staff (five to six scans in one clinical session);

- given consideration to increasing the number of triage 3 referrals that can be accepted, which would allow the DHB to provide screening for ASNHL.

NMDHB sincerely regrets that it could not provide an MRI scan to Mrs A in the first half of 2007. However, it considers that its management of Mrs A was appropriate. It has since increased its resource in the Radiology service and is now able to accept routine referrals for public patients with ASNHL. The public ENT service is now also accepting these referrals from GPs. The service still does not accept referrals from private specialist rooms.

ACC claim
On 14 November 2008 Mrs A made a treatment injury claim in relation to her acoustic neuroma. She claimed that the delays in obtaining outpatient appointments and the MRI scan caused a worsening of her condition. External clinical advice was provided by Dr William Wallis, a neurology specialist. On 10 December 2008 Dr Wallis advised:

> "The form requesting the MRI scan by [Dr B] is not available in the notes, but [Dr B] mentioned a MRI imaging with attention to the acoustic areas, undoubtedly raising the suspicion on an acoustic neuroma. How and why this request was considered to be of such a low priority as to be rejected by the Nelson radiology department, however, is difficult to understand and is not specified in the information provided by the radiology department. … In my opinion, there were several unacceptable delays in this patient's management. The first was rejection of [Dr C's] request for an ENT opinion at the Wairau Hospital. The second was an unexplained refusal to carry out [Dr B's] request for an MRI scan, which the radiology department in Nelson considered to be of such low priority that they would not perform the test. The third was a further delay that required the patient's GP to place increasing pressure on the system to have the test done. … Until she saw a neurosurgeon, [Mrs A] was inexplicably let down by the public hospital system. Although one might blame resource allocations decisions I believe that the problem was rather a failure to appreciate the indications for an early ENT opinion and an early MRI scan. In my opinion these delays and refusals to arrange appropriate and early evaluation were and are unacceptable."

On 30 December 2008 ACC advised Mrs A that it had accepted her claim as treatment injury.

Research on screening patients with ASNHL for acoustic neuroma
In March 2009, the Health Services Assessment Collaboration published a report on the systematic review of the literature available on the role of magnetic resonance imaging (MRI) and comparative surveillance techniques in screening for the early

detection of acoustic neuroma in patients with ASNHL. It was commissioned by the Ministry of Health. The literature suggests that MRI is considered the gold standard in detecting acoustic neuromas in patients with ASNHL. Although auditory brainstem response (ABR) testing is also widely used, it has been shown to have insufficient sensitivity and specificity to be used as a sole screening test. The report notes that there is significant variety in the way clinicians screen and manage patients presenting with ASNHL. "This may be due to the fact that there are no universally agreed upon clinical practice guidelines, and because of accessibility and cost issues of screening patients with MRI."[10]

In April 2009, the National Institute for Health Research (Health Technology Assessment programme) in the United Kingdom published research on "The role of Magnetic Resonance imaging in the identification of suspected acoustic neuroma: a systematic review of clinical and cost effectiveness and natural history".[11]

Future developments
In July 2009, the Ministerial Review Group (MRG) released its report "Meeting the Challenge". The MRG considered equity issues raised because people with similar conditions and health needs have unequal access to health services depending on where they live. There are concerns that leaving individual DHBs to determine their own priorities will lead to "postcode" access to radiology and other diagnostic services.[12] The MRG noted that the current mechanisms for assessing the effectiveness and relative priority of health interventions are not well developed.

In future, it is expected that the National Health Board and National Health Committee will be involved in determining which procedures and interventions will be eligible for public funding, and the conditions under which they should be applied.[13] The aim is to ensure evidence-driven prioritisation to ensure greater national consistency of access, while appreciating that there may be some local variation.

---

[10] Peach, D and Weston A, "Screening in ASNHL for acoustic neuroma". *HSAC*, March 2009. Available at: http://www.healthsac.net.
[11] Available at: http://www.hta.ac.uk/1514.
[12] Cameron, A, "Under my skin — A scan of radiology services". *New Zealand Doctor*, 15 July 2009, p 12. Available at: www.nzdoctor.co.nz.
[13] Ministerial Review Group, "Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand" (31 July 2009), paragraph 73, page 30. On 19 March 2010 the Minister of Health released the December 2009 Cabinet Paper and minute which agreed, in principle, to reconfigure and strengthen the National Health Committee so that it focuses on prioritisation.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) 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.

RIGHT 6

Right to be Fully Informed

(2) 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 — Nelson Marlborough DHB

Introduction
Nelson Marlborough DHB owed Mrs A a duty of care to ensure her referral for a specialist assessment and diagnostic service was managed appropriately.[14] To meet its duty of care, Nelson Marlborough DHB needed to:

1. appropriately assess and prioritise Mrs A's level of need using relevant standards and/or guidelines;

2. promptly and clearly inform Mrs A and the referrer about:

   (a) the decision and reasons for it — that the publicly funded service was not available to people with her level of need at this time;

   (b) management options — including the option of seeking private treatment, and the risks (if any) of no treatment; and

   (c) the need to monitor her condition and notify the DHB of any deterioration.

Prioritisation systems should be fair, systematic, consistent, evidence-based and transparent.[15] Under the Ministry of Health national service specification, Nelson

[14] See also case 04HDC13909, 4 April 2006.

Marlborough DHB had a duty to develop, implement and manage booking systems for all medical, surgical and diagnostic services. If the DHB could not meet the ongoing demand for diagnostic services within six months of referral, the specification required it to prioritise referrals, notify referrers and patients of the ability or inability to provide services within the minimum six-month period, and give referrers information about the level of need or priority that could be serviced, together with referral or management guidelines to enable general practitioners to manage the patient's plan of care and review or reassess the patient's condition as appropriate.

The Ministry of Health guide to elective services at public hospitals explains the process for managing a patient's care if the patient needs elective services at a public hospital.[16] The process for managing the care should be *clear, fair* and *timely*. The guideline states that a patient will receive information about assessment and treatment options and whether or not these will be available to the patient. The patient will know within 10 days whether he or she will receive access for assessment or treatment. If assessment or treatment is offered, the patient will receive it within the next six months. The patient's level of need will be assessed in comparison with other people with similar conditions.

In my view, Nelson Marlborough DHB failed to fulfil its duty of care to Mrs A. I have considered the overall picture of care and then analysed the standard of care and adequacy of the information in relation to Mrs A's referrals for a specialist assessment in February 2006 and April 2008 and referral for a diagnostic service (MRI) in December 2006.

General comments re access to publicly funded services
Nelson Marlborough DHB had a duty to appropriately manage the booking system for ENT and radiology services. In early 2007, the DHB made a considered decision not to provide publicly funded MRI scans for routine patients with ASNHL.

It made this decision via a clinically led, consultative and transparent decision-making process. ENT specialists, who were deeply concerned about their patients' safety and their own medico-legal risk, were strongly opposed to the decision not to fund MRI scans for patients with ASNHL. The DHB was made acutely aware that its decision not to fund routine MRIs for such patients was out of line with other district health boards. At the time, most, if not all, district health boards provided publicly funded services (FSA[17] and MRI scans) for patients with ASNHL. In other regions, it was standard practice to endeavour to assess and scan such patients within six months of a referral. Dr B questioned whether it is reasonable for a patient to be denied access to a particular service in these circumstances.

[15] Medical Council of New Zealand, Statement on Safe Practice in an Environment of Resource Limitation (Wellington, October 2005), para 18.
[16] Ministry of Health, "A Guide to Elective Services at Public Hospitals". Ministry of Health (2007). Available at: www.electiveservices.govt.nz.
[17] First Specialist Assessments.

Mrs A was denied access to a publicly funded MRI scan. It is natural to feel considerable sympathy for Mrs A and her family, who have suffered greatly as a result of the significant delays in her care. It is also understandable that she feels let down by the public health system. It is unfair that other patients with ASNHL living anywhere but Nelson/Marlborough would have been accepted on a waitlist for MRI and received an MRI scan well before Mrs A actually received one, in August 2008. It is inequitable that New Zealanders with similar needs do not receive similar access to publicly funded services. It is no surprise that the system has been described as a "postcode lottery". The DHB system exists to respond to local needs. However, it is clear that greater national consistency is required.

If a DHB has broader concerns about a specialist's prioritisation practice — like the issues raised about prioritisation in the Southland District Health Board report[18] or concerns about queue jumping by private patients — they should be addressed promptly and transparently.

Referral for specialist assessment — February 2006 and April 2008
Mrs A was first referred to the ENT department at Wairau Hospital in February 2006. Her referral was graded as non-urgent on the basis of the information provided — ASNHL and tinnitus with no neurological findings. Mrs A and her general practitioner were informed that the Nelson Marlborough DHB was unable to see her because she had been graded as a "routine" patient. It was recommended that she go back to her general practitioner if the situation deteriorated, for further advice about management of her symptoms.

My ENT expert, otolaryngologist Dr Ferguson, commented that the advice and explanation provided to Mrs A was reasonable and she was provided with information about what to do next if the situation changed. My radiology expert, Dr Murdoch, also commented that the information was clear, and included specific advice if Mrs A felt her condition deteriorated.

On 1 April 2008 Mrs A was referred back to Dr B at the public hospital. Dr Ferguson advised that her "appointment was graded as a 3–6 month appointment which I think is appropriate on the information provided and then when her symptoms deteriorated she was re-referred and seen in a very timely manner, both in the ENT Department and then by the Radiology department to arrange her MRI. At this point the care provided by the DHB was appropriate."

Referral for diagnostic service (MRI) — December 2006
As advised, Mrs A consulted her general practitioner when her condition worsened in late 2006; she experienced episodes of vertigo and loss of balance. She was referred to a private ENT specialist for assessment. In December 2006 the ENT specialist referred her to Nelson Marlborough DHB for a semi-urgent MRI scan (triage 3). Dr B graded the referral semi-urgent because Mrs A had developed symptoms indicating more urgency than a routine referral for ASNHL.

[18] Case 04HDC13909, 4 April 2006.

The Radiology department at NMDHB then effectively downgraded her priority and managed her as a routine referral (triage 4). NMDHB explained that the referral did not meet the urgency criteria operative in the ENT department at the time. Thus, the prioritisation in Radiology was in line with the ENT service. In May 2007, Mrs A was declined access to a publicly funded MRI as she was not considered to be sufficiently urgent.

I find it inexplicable that Mrs A did not meet the urgency criteria operative in the ENT department. At the time, the referring ENT surgeon was working in the department as well as privately, and should have been familiar with the urgency criteria that were operative. I also note that when Mrs A was subsequently referred to the ENT department by her GP (April 2008) she was suffering from the same symptoms she had at the time of the MRI referral. At that time, the ENT department stated that she was reviewed using government referral criteria, and her appointment was rated as semi-urgent (T3).

Adequacy of assessment and prioritisation
Under Right 4(1) of the Code, Mrs A had a right to an appropriate assessment and prioritisation of her level of need using relevant standards and/or guidelines.

There was a significant difference in the way NMDHB managed routine patients with ASNHL and those with other symptoms suggesting greater urgency. NMDHB declined access to MRI for routine patients, but accepted patients with ASNHL exhibiting symptoms and signs indicating more urgency.[19]

Dr Ferguson, otolaryngologist, considered that the prioritisation of the MRI scan as "semi-urgent" was "completely appropriate as the investigation was being ordered to exclude a specific pathology". She subsequently clarified that Mrs A's additional symptoms, in particular her vertigo and loss of balance, warranted the higher prioritisation by Dr B in this case. Dr Murdoch, radiologist, advised that Mrs A's MRI referral would usually be prioritised as "routine" in most DHB radiology departments based on the clinical information, radiological guidelines and her personal experience. However, she noted that she could not comment on the appropriateness of Dr B's diagnosis.

Dr MacDonald, radiologist, commented that "[d]etailed knowledge of clinical symptoms and examination findings, non-imaging investigations, management options, and risks and outcome data related to different options, is beyond the scope of training of a diagnostic radiologist. For the purposes of determining whether or not imaging is appropriate and with what level of urgency it should be carried out, Radiologists are dependent on the assessment of referring clinicians, which is typically communicated via a summary of the relevant clinical details on a referral form. Clinic letters and clinical notes detailing the specialist assessment are not

[19] NMDHB's GP advice sheet on ASNHL also advises that for patients with ASNHL, concern is higher if they exhibit certain signs and symptoms, including atypical vertigo.

routinely available or sought in the context of providing diagnostic imaging services, nor is review of the patient undertaken."

Dr B was in the best position to assess Mrs A and determine whether any clinical symptoms, such as vertigo and loss of balance, suggested urgency. Dr Ferguson supports his assessment. Mrs A had symptoms and signs indicating more urgency than a routine referral for an MRI. In my view, NMDHB failed to manage the referral appropriately by the inappropriate downgrading of the urgency — in a manner inconsistent with NMDHB's own criteria and at variance with the indication of the referring specialist. Mrs A should have been accepted on the waitlist for an MRI in accordance with NMDHB's own policy.

I acknowledge that radiologists *may* triage at variance to the level of urgency indicated by the referring clinician in order to ensure fairness and consistency across all patients referred to radiology. Nevertheless, overriding a specialist's assessment of a patient's priority should never be done lightly and should involve clear communication to the relevant referrer of the change in priority, in case some important clinical information has been overlooked. This affords the referrer the opportunity to provide further relevant information to support the referral.

It appears that important clinical information was overlooked in this case when the referral was triaged as routine. NMDHB submitted that some important clinical information was not available to the prioritising radiologist. The referral did not refer to "loss of balance", which would indicate more urgency, whereas "vertigo" would not. NMDHB submitted that Dr B had the opportunity to re-refer Mrs A with more information. He did not do so.

The referral did not refer to "loss of balance". However, it did refer to the additional symptom "vertigo", and was marked semi-urgent. I note that NMDHB's advice sheet provides that concern is higher if vertigo is present. The prioritisation of the referral as routine was not in line with the urgency criteria operative in the ENT department, as noted above. In any event, I do not accept that NMDHB clearly advised Dr B that the referral had been downgraded. Both of my independent advisors concur on this (discussed below).

Conclusion — assessment and prioritisation
In my view, NMDHB did not appropriately assess and prioritise Mrs A's level of need for an MRI in May 2007. As a result, she was denied access to a publicly funded MRI. I conclude that NMDHB breached Right 4(1) of the Code.

Adequacy of information

Under Right 6(1) of the Code, Mrs A had a right to timely information about the outcome of the referral, including specific advice about whether she was likely to receive an MRI. She had the right to be told about what other options were available to her, such as the right to seek a private MRI and treatment if publicly funded services were not available. Mrs A also had the right to be told what her symptoms meant and to be informed of the risks of not being seen "semi-urgently".

Mrs A was referred by an ENT surgeon to NMDHB for a "semi-urgent" MRI scan in December 2006. It appears that Mrs A was initially placed on the waiting list for an MRI scan, but on 11 May 2007 she was informed via a letter to Dr B and copied to her that she would not receive a publicly funded MRI scan. The letter stated:

> "Although your referral was wait-listed for a publicly funded examination, it is now apparent that the demand for more urgent examinations means that in effect your requested examination will not get done. Other appropriate ways of investigation may be available and these alternatives should be reviewed."

Dr Murdoch advised that the wording does not clearly indicate how the MRI request was prioritised in Radiology. The implication is that it was felt to be a lower priority in comparison to the demand for more urgent examinations. The letter also gives advice on further management. Dr Murdoch considered that the letter was clear, and appropriately phrased to a clinical colleague, with reasons why the referral was declined.

Dr Ferguson advised that the letter of 11 May 2007 "does not actually state, and I could not find this in the file, that they had downgraded the prioritisation to routine from semi-urgent but that they were no longer able to provide it. It certainly might imply that they had downgraded the prioritisation to routine but it is not specifically mentioned." Dr Ferguson noted that the correspondence suggested that there might be other appropriate means of investigation. However, there was no specific recommendation as to what further investigation might be available to Mrs A, what alternatives were available to her or what she should do if her symptoms changed. Dr Ferguson also noted that there was a five-month delay between the referral for the MRI scan and the decision not to provide that service. She concluded, "[I]n this respect I do not consider that the Nelson Marlborough District Health Board gave appropriate or timely care and advice to either [Mrs A], her general practitioner or to [Dr B]."

It took five months for Mrs A to be advised by NMDHB about whether she was able to receive a publicly funded MRI. NMDHB considers the delay was, in all the circumstances, reasonable. NMDHB stated that Mrs A was originally wait-listed, and then taken off. I have considered the steps taken by NMDHB to respond to the unexpected surge in demand for the local service. These steps do not excuse the communication delays. Mrs A was left in the dark about the referral.

I also have concerns about the adequacy of the advice provided to Mrs A about her management options and the risks of not having a timely MRI scan. Mrs A was reassured because she had been told she did not need urgent care. She did not think anything was wrong with her because her care was considered of such low priority.

NMDHB submitted that it was not the role of the Radiology department, or the radiologists, to advise Mrs A about her ongoing treatment options. The responsibility falls on the referring ENT surgeon to provide this advice. Dr MacDonald comments extensively on this issue. I accept that the ENT surgeon had the primary responsibility to provide Mrs A with the information about management options and the risks of not proceeding with an MRI as recommended (discussed below).

Conclusion — adequacy of information
I conclude that NMDHB also breached Right 6(1) of the Code owing to the lack of clarity and timeliness of the advice it provided to Mrs A.

Other comment — specialist's duty to follow up referral
The radiology referral system in New Zealand has been described as a specialist gatekeeper system that "handicaps GPs and sees patients queuing for a radiology referral".[20] However, concomitant with a specialist's right to make a radiology referral is the responsibility to follow up such referrals. It is essential that DHBs, specialists and GPs work together to ensure quality and continuity of care for patients who have been referred for secondary care.

In December 2006 Mrs A saw an ENT specialist in private and was referred for an MRI scan. As noted by Dr Ferguson, the specialist does not appear to have had any formal communication with the DHB or Mrs A until she presented again in 2008. While I acknowledge that Dr B has been a strong advocate for Mrs A, it appears that he did not make any further efforts to follow up her care. He did not take any steps to actively follow up his referral and Mrs A's status on the MRI waiting list for over five months. It was also Dr B's responsibility, as Mrs A's specialist, to ensure that she was provided with the information she needed to know about the risks of not proceeding with an MRI as recommended. This would have been consistent with good quality care.

If a patient's healthcare providers do not work together to ensure that patients waiting for investigations are kept well informed and managed, it is inevitable that some patients will be left in limbo, possibly compromising their care. That is what happened to Mrs A.

[20] Cameron, A, "Under my skin — A scan of radiology services". *New Zealand Doctor*, 15 July 2009, p 12: available at www.nzdoctor.co.nz.

Recommendation

I recommend that Nelson Marlborough District Health Board apologise in writing to Mrs A for breaching the Code. The apology is to be sent to HDC and will be forwarded to Mrs A.

Follow-up actions

A copy of this report, with details identifying the parties removed except the experts who advised on this case and Wairau Hospital, Nelson Hospital and the Nelson Marlborough District Health Board, will be sent to the Minister of Health and the Director-General of Health, the National Advisory Committee on Health and Disability, ACC, the New Zealand Society of Otolaryngology Head and Neck Surgery, the Royal Australasian College of Surgeons, 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.

Appendix 1

Independent advice to Commissioner — ENT

The following expert advice was obtained from otolaryngologist Dr Catherine Ferguson:

"I have been asked to provide an opinion to the Commissioner on Case No. 09/00891. I have read and agreed to follow the Commissioner's guidelines for independent advisors.

I hold a fellowship with the Royal Australasian College of Surgeons in Otolaryngology, Head & Neck Surgery. I am a New Zealand trained graduate, vocationally registered in the field of general otolaryngology, including the management of ear disease, and practice in the greater Wellington area.

I have been asked to provide independent advice about the appropriateness of care and adequacy of the information provided to [Mrs A] by the Nelson Marlborough District Health Board between 2006 and 2008, including the adequacy of the actions taken by the Nelson Marlborough District Health Board to ensure that [Mrs A] received timely services following referrals for a specialist appointment and MRI scan.

Included in the information provided to me I have read:

- A summary of the case
- [Mrs A's] letter of complaint
- Nelson Marlborough District Health Board's response
- [Mrs A's] clinical records
- Further information from the Nelson Marlborough District Health Board in regards to referrals for scans
- [Mrs A's] medical records from [Dr C]
- Information received from [Dr B].

History

In February 2005 [Mrs A] consulted her general practitioner about hearing loss in the right ear and was referred to an audiologist. In November 2005 [Mrs A] was seen by an audiologist at Wairau Hospital and it was recommended that she be referred to an ENT specialist. On 5 February 2006 [Mrs A's] GP referred her to the ENT Department at Wairau Hospital for this further assessment. The referral was prioritised as non-urgent and [Mrs A] and [Dr C] were advised that she could not be seen and that she should consult her general practitioner should her symptoms become worse.

In November 2006 [Mrs A] consulted her general practitioner again relating to some new ear symptoms and she was referred to a private otolaryngologist for

assessment. She was seen by [Dr B] at his private clinic on 4 December 2006. An MRI scan through the public hospital was requested. In May 2007 [Dr B], [Mrs A] and her GP were informed that while she had previously been on the waiting list for an MRI scan it was no longer possible to be performed.

In April 2008 [Mrs A] consulted her general practitioner again with worsening symptoms and her general practitioner wrote to [Dr B] at Wairau Hospital asking if she could be reviewed. She was informed that she would be seen within 3–6 months but two months later she was having worsening symptoms and she was given an appointment for 20 August. She was then referred for an MRI scan urgently which confirmed a 4cm tumour on her balance nerve. Following that she was referred urgently to Christchurch where she underwent surgery on 16 September 2008.

Summary

I have been asked to provide independent advice about the appropriateness of the care and adequacy of information provided to [Mrs A] by Nelson Marlborough District Health Board. The interactions between [Mrs A] and the DHB occurred on a number of different occasions and I will deal with them in chronological order.

1. [Mrs A] was first referred to the ENT Department at Wairau Hospital in February 2006 and her referral was graded as non-urgent on the basis of the information provided. [Mrs A] and her general practitioner were informed that the Nelson Marlborough District Health Board was unable to see her because she had been graded as a routine patient. It was recommended that she should go back to her general practitioner if the situation deteriorated for further advice about management of her symptoms. In this respect I consider that the advice and explanation provided to [Mrs A] was reasonable and she was provided with information as to what to do next if the situation changed. [Mrs A] in fact did then seek further advice from her general practitioner when the condition got worse and elected to be seen privately.

2. In December 2006 [Mrs A] consulted the ENT surgeon privately and was referred to Nelson Marlborough District Health Board for an MRI scan. It was considered that this was a semi-urgent referral. It appears that [Mrs A] was placed on the waiting list for an MRI scan but then on 11 May 2007 she was informed that the procedure could not be performed in the public sector after all because of demand for more urgent examinations. It was suggested that there might be other appropriate ways of investigation. However, there was no recommendation as to what further investigation might be available to [Mrs A], what alternatives were available to her or what she should do if her symptoms changed. I also note that there was a five month delay between the referral for the MRI scan and the decision not to provide that service. In this respect I do not consider that the Nelson Marlborough District Health Board gave appropriate or timely care and advice to either [Mrs A], her general practitioner or to [Dr B]. However, I note that it is not apparent from either her

general practitioner's notes or any hospital records that any further effort to expedite a scan was made at this stage until [Mrs A] presented again in 2008.

3. On 1 April [Mrs A] was referred back to [Dr B] in the public hospital. Her appointment was graded as a 3–6 month appointment which I think is appropriate on the information provided and then when her symptoms deteriorated she was re-referred and seen in a very timely manner, both in the ENT Department and then by the Radiology Department to arrange her MRI. At this point the care provided by the DHB was appropriate.

I note in the documents provided to me that there is now a new letter sent out by the Nelson Marlborough District Health Board, advising people that they will not be able to have an MRI scan done through the public hospital. However, now they do make recommendations for further testing and mention the option of having a private MRI scan. These options were not provided to [Mrs A] at the time she was turned down for her MRI scan. It is pleasing to see that the processes have been revised but it is unfortunate that [Mrs A's] situation was the catalyst for this."

Appendix 2

Independent advice to Commissioner — radiology

The following expert advice was obtained from radiologist Dr Jean Murdoch:

> "I have agreed to provide an opinion to the Commissioner on case number 0900891, as above. I confirm that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> My name is Dr Monica Jean Murdoch. I am known as Dr Jean Murdoch. I hold a BA (psych) and MD from the University of British Columbia, Canada. I am a fellow of the Royal College of Physicians and Surgeons of Canada (1995) and the Royal Australian and New Zealand College of Radiologists (2009). I have been employed as a Radiologist at Wellington Hospital since 1996. During that time, in addition to my clinical duties, I have held a number of administrative positions, including seven years as Radiology Services Clinical Leader, and member of the DHB Medical Reference Group and nine years as Principle National Radiation Laboratory Licensee for Capital and Coast DHB.
>
> Quoting your letter, I have been asked:
>
> > 'To provide independent advice about the appropriateness of the care and adequacy of the information provided to [Mrs A] by Nelson Marlborough District Health Board between 2006 and 2008, including the adequacy of the actions taken by Nelson Marlborough District Health Board to ensure that [Mrs A] received timely services following referrals for a specialist appointment and MRI scan.
> >
> > To provide independent advice on any other aspects of the care provided that [I] consider warrant additional comment.'
>
> I have been provided with and have read the following documents as background information for my opinion:
>
> - [Mrs A's] letter of complaint to the Health and Disability Commissioner
> - [Mrs A's] letter of complaint to Nelson Marlborough District Health Board (NMDHB)
> - NMDHB's response to [Mrs A]
> - NMDHB's response to request for information from HDC
> - A copy of [Mrs A's] written clinical records from NMDHB
> - Copies of correspondence between NMDHB ENT department, Clinical Advisory Group and Chief Operating Officer and Radiology department
> - A copy of [Mrs A's] ACC Treatment Injury Report and Treatment Injury Advice
> - A copy of [Mrs A's] medical notes from her general practitioner, [Dr C]
> - Copies of correspondence and medical notes from [Dr B]

- A copy of *Screening for the early detection of acoustic neuroma in patients with asymmetric sensorineural hearing loss: a brief overview of MRI and other surveillance methods. A systematic review of the literature*
- A copy of *Screening patients with sensorineural hearing loss for vestibular schwannoma using a Bayesian classifier. Nouraei, Huys et al. Clinical Otolarygology 2007, 32, 248–254.*

I have also accessed the American College of Radiology Appropriateness Criteria for Vertigo and Hearing loss and the Ministry of Health Elective Services Guidelines.

These can be found at the following URLs:

– http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria/pdf/ExpertPanelonNeurologicImaging/VertigoandHearingLossDoc14.aspx
– http://www.electiveservices.govt.nz/guidelineinfo.html

I note the summary of events as provided in chronologic order by your office in the undated report entitled 'Medical/Professional Expert Advice – 09HDC00891'. I note that the supportive documentation supplied confirms the summary of events, which I summarise here:

Date	Event	Source	Comment
17/02/05	GP consultation	GP medical notes	Difficult with hearing and pain in right ear. Treatment plan indicates 'Audiology'
10/11/05	Audiology consultation	GP medical notes	Tinnitus continual on right side. Asymmetric tinnitus and sensorineural hearing loss. ENT referral recommended to exclude retrocochlear pathology.
05/02/06	Specialist ENT referral Wairau Hospital	Letter from GP medical notes	Tinnitus right ear and mild sensorineural hearing loss
07/02/06	Letter received at Wairau ENT Outpatients	Notes from [Dr B]	Stamped '6/12+' – this note is dated 10/02/06 and initialled, but the initials are illegible.
14/02/06	Letter to patient and GP	Notes from [Dr B]	Indicated ENT has graded the referral as 'routine'. Large numbers of patients with greater urgency, therefore unable to provide an outpatient appointment. Recommended to consult GP if her condition worsened.
10/11/06	GP consultation	GP medical notes	New complaint of vertigo/balance loss.
11/11/06	Referral to private ENT	Letter from GP medical notes	Long-term symptoms of tinnitus and decreased hearing in right ear and more recent symptoms of vertigo.
04/12/06	[Dr B] consulted at his private clinic	Letter from GP medical notes and [Dr B] notes	Assessed as asymmetric sensorineural hearing loss and unilateral tinnitus – ?cause Right benign paroxysmal positional vertigo

			Recommended MRI brain scan
04/12/06	MRI referral to Nelson Hospital ENT secretary	Notes from [Dr B]	Clinical details provided: 'Unilateral R tinnitus & hearing loss. Paroxysmal rotation, vertigo'. 'Semi-urgent' box ticked.
11/05/07	Letter to [Dr B] and patient from NMDHB	Letter from [Dr E] in GP medical notes	Referral rate far outweighing ability to provide service to all patients. Due to demand for more urgent examinations the requested examination will not get done.
01/04/08	GP referral to [Dr B] at ENT Outpatients Wairau Hospital	Letter from GP medical notes. Cannot see the consultation in GP notes	Suffering from the same symptoms and finding tinnitus most annoying.
undated	Letter of referral stamped by [Dr B]	Copy of letter in notes from [Dr B]	Hand-written note on letter states '1st referral'. Stamp indicates 'T3' for a 15 minute clinic appointment with [Dr B] and 'Audio'
17/04/08	Letter from Wairau Hospital ENT secretary to patient	Notes from [Dr B]	Using 'Government Referral Criteria' the referral was graded 'semi urgent', with a wait of 3–6 months for the appointment. Advised to contact family doctor if deteriorates or changes.
22/06/08	Letter from GP to Wairau ENT outpatients	Letter from GP medical notes. Cannot see the consultation in GP notes	Advising balance is now affected and 'veering off course' when walking. No other new neurological symptoms.
23/06/08	Above letter received at Wairau ENT outpatients	Notes from [Dr B]	
16/07/08	Letter stamped by [Dr B]	Notes from [Dr B]	Hand-written note on letter states '2nd referral'. Stamp indicates 'T1' for a 15 minute clinic appointment with [Dr B] and 'Audio'
20/08/08	Wairau Hospital ENT Clinic letter	Notes from [Dr B]	Problem: progressive right unilateral hearing loss and tinnitus. Incoordination and ataxia. MRI Head scan and acoustic series recommended. Indicated he discussed this with [a] Radiologist at Nelson Hospital. At this point also concerned that previous request for MRI 18 months ago had been declined.
20/08/08	MRI referral	MRI referral form from [Dr B's] notes	Clinical Details: progressive deterioration R hearing, increasing tinnitus, reduced R corneal reflex, mild ataxic gait, mild incoordination on R [illegible] falls over last 2/12 *Refused MRI by NMDHB 18/12 ago This referral is stamped '29 Aug 2008'
29/08/08	MRI scan	This is noted in the HDC summary	Right acoustic neuroma diagnosed. Size measurements variably described in the information available. I cannot see a report of the MRI in the

			information provided.

29/08/08	ENT outpatient appointment	Letter in GP medical notes	See below
01/09/08	Letter from Neurosurgeon to [Dr B]	GP medical notes	Regarding urgent faxed consultation on 29/08/08 regarding the results of the MRI. Neurosurgical intervention considered only treatment option.
05/09/08	Wairau Hospital ENT letter to GP	GP medical notes	Follow up ENT appointment on the day of the scan (above). Patient referred to neurosurgery team in Christchurch.
16/09/08	Subtotal removal of right acoustic Neuroma	Copy of Neurosurgical Inpatient Summary from CDHB in Wairau Hospital medical notes	Admitted 12/09/08 Discharged 24/09/08 Persistent post-op tinnitus and hearing loss right ear. Normal right facial movements and sensation (preserved lower cranial nerve function).

Various communications between several NMDHB hospital services, the Chief Medical Advisor and Clinical Advisory Group and other clinical groups have also been included. These provide evidence of background discussions on access to MRI screening for acoustic neuroma. These communications are dated from the end of November 2008 to April 2009.

Appropriateness of care

In the New Zealand Public Health system resources are limited and decisions must be made on a daily basis about patient access to care. Patients with urgent, potentially life-threatening conditions must be given highest priority. Patients with potentially serious conditions that could result in significant disability have moderate priority and patients with less-clearly defined conditions, including conditions that are detected for screening purposes, have the lowest priority. Decisions about priority and access to specialist assessment and investigation will always have the inherent risk of missing potentially important pathology.

Much comment has been made in popular media about access to care, and clinical guidelines have been developed both nationally and at local DHB level to try and give patients (and clinicians) some degree of certainty about access to specialist appointments and investigations. Some of the most widely discussed are the criteria for access to first specialist appointment, with Ministry of Health (MoH) guidelines indicating '… all patients referred to hospital by their GP who can be seen within the available resources, are seen for a first specialist assessment within six months ... all patients assigned a priority by a specialist are managed in accordance with that priority (relative to the priorities assigned to other patients managed by that service) … all patients have a plan of care.' I believe the last

point is directed at the continuing monitoring of patients who do not meet criteria for first specialist assessment or investigation in order to minimise the risk of missing important pathology.

I can make only limited comment on the appropriateness of care provided by the ENT service at Wairau Hospital. I note that on the basis of the information available at the time of the first GP referral, [Mrs A] was felt to have a clinically 'routine' condition, as stated in the letter sent in February 2006. No background information has been provided on the numbers of referrals to the ENT service during this time, other than the information in the letter which indicates there were a large number of more urgent referrals waiting to be seen. On this basis, the referral was declined. The patient and her GP were given suggestions for ongoing management of her condition. This mainly centred on attending her GP for further follow-up and for her GP to consult a specialist for further advice, as needed.

[Mrs A] was subsequently seen at [Dr B's] private ENT clinic in December 2006. On the basis of his assessment, she was felt to have 'benign paroxysmal positional vertigo'. I cannot comment on the appropriateness of this diagnosis, specifically. The ACR Appropriateness Criteria state 'There are no radiological findings in patients with benign positional vertigo'. However, in my experience, it is still common for specialists to refer patients for imaging with symptoms of tinnitus. These referrals are on a non-urgent basis to rule out other less common causes of vertigo and tinnitus. It is recognised that acoustic neuroma accounts for somewhere between 3–7% of cases of tinnitus. This is specifically noted in the conclusions of the HSAC literature review '*Screening for the early detection of acoustic neuroma in patients with asymmetric sensorineural hearing loss: a brief overview of MRI and other surveillance methods'.* Therefore, it is clear there is a balance between the cost of providing MRI in this type of non-urgent case, limitations of resource, the need to provide access to patients with conditions of greater clinical urgency and the risk of missing some tumors. I believe this balance is also recognised in the MoH guidelines, as indicated by the quote above.

The first MRI referral was prioritised as 'semi-urgent' by [Dr B], though based on the clinical information on the form, radiological guidelines and my personal experience of MRI referrals, this would usually be prioritised in most DHB Radiology departments as 'routine' for the reasons outlined above. The letter from [Dr E] in reply to this MRI referral essentially shows the same issues of resource limitations as the earlier letter from Wairau ENT Outpatients declining [Mrs A's] first referral for assessment. While the wording does not clearly indicate how the MRI request was prioritised in Radiology, it implies this was felt to be a lower priority in comparison to the demand for more urgent examinations. The letter also gives advice on further management in this situation.

There is no information available to me on [Dr B's] response to the fact his MRI request was declined. It is unclear if any follow-up appointment occurred, other

investigations were considered or if further instructions or advice were provided to [Dr C].

When [Mrs A] was re-referred to [Dr B] at Wairau Hospital ENT Outpatients in April 2008, this was identified as a 'first referral', though she had been referred to the Outpatient ENT clinic once before (but did not meet criteria to be seen) and had been seen by [Dr B] in his private clinic. The referral letter pointed out that [Dr B] had seen [Mrs A] in his private clinic some time before. At this point, she met the criteria to be seen within three to six months. This might be considered a semi-urgent referral.

The letter from [Dr C] shortly after, in June 2008, was identified as a 'second referral'. Accordingly, this was upgraded to a more urgent (less than 1 month) referral when it was prioritised in mid July. [Mrs A] was then seen just over 1 month from the prioritisation date, or just over 2 months from the date the referral was received. The assessment showed progression of findings and resulted in the referral for an urgent MRI scan at Nelson Hospital. [Dr B] ensured the urgency of the referral was clearly communicated by telephoning one of the Radiologists at Nelson Hospital.

The MRI was then carried out 29 August 2008, six working days after the referral.

The NMDHB MRI service was established early in 2007. According to the information provided to me, this was a shared access arrangement between a private Radiology provider and the DHB. NMDHB access was limited to 3 sessions per week. According to an email from Dr E (included in the DHB records) the waiting times for MRI were increasing by approximately 1 week every week, with 160 patients on the waiting list less than 1 month after the service started. It has been my experience that the start up phase of any new imaging service can be a difficult period as staff adjust to the demands of the new service, and become familiar with the associated clinical and technical challenges. This is often accompanied by a surge of referrals, as various constraints are perceived to have been removed. When the MRI service started at Wellington Hospital we had similar difficulties in coping with the volume of referrals. It was predicted that the volume of referrals would 'settle down' after a period, however, this has not yet happened in the 12 years since the service was established and is an ongoing significant challenge. It would seem that the NMDHB experience has been similar. The NMDHB Radiology department recognised the risks of this situation very quickly and attempted to increase the funding for access to MRI time, however, this was declined due to budgetary restrictions faced by NMDHB. The subsequent decision to limit access to MRI to more urgent cases is, in my opinion, appropriate, though this decision is not without risk.

Adequacy of information provided to [Mrs A]

The information communicated to [Mrs A] by letter from the Wairau ENT Outpatient department was clear, and included specific advice if she felt her condition deteriorated. The letter to [Dr B] from the Nelson Hospital Radiology department was equally clear, and was appropriately phrased to a clinical colleague, including reasons why the referral was declined.

Adequacy of the actions taken by Nelson Marlborough District Health Board for timely service following referrals for a specialist appointment and MRI scan.

It is my opinion that NMDHB actions around timely service following referral for a specialist appointment were adequate. Clear information was given as to the reason the initial referral was declined and advice provided on ongoing care from the GP. When the patient was referred a second time to the public system, the referral was appropriately prioritised, and again very clear advice was given on actions to take should [Mrs A's] condition deteriorate. This advice was followed shortly after, which resulted in a prompt appointment to see the ENT specialist. The actions taken after this appointment were also appropriate.

There were two referrals for MRI in this case. The first referral was prioritised by ENT as 'semi-urgent' and by Radiology as 'routine'. This re-prioritisation by the Radiology department is appropriate and consistent with established guidelines. I note literature provided by ENT and subsequent correspondence in the NMDHB records both support a 'routine' priority for this referral. Given the prior decision to limit MRI referrals to more urgent cases, and in effect ensure that only referrals that could be processed within the MoH guidelines of 6 months were accepted, this would therefore be consistent and appropriate. Access to imaging was also prompt and appropriate when the patient was judged by the ENT service to have a more urgent clinical condition.

Comments on other aspects of care

[Dr B] recorded in his notes dated 20/08/08 his concern that the previous MRI referral had been declined 18 months ago. Until that time this patient was regarded as at the most 'semi-urgent'. In addition there had been no clinical follow-up provided at the time the first MRI referral was declined. Additional action on the part of the ENT service in the form of advice to the GP or Specialist re-assessment may have informed a decision to pursue the MRI scanning earlier.

I am also concerned at a comment made in an undated letter to [NMDHB Chief Medical Advisor] (stamped 'received' 20 August 2008). The letter mentions an email (not provided to me) from [the] NMDHB [Chief Operating Officer] that states 'In regards to the patient you mention, we *(presumably the NMDHB)* would be fully supportive of you, it is a resourcing issue and consequently out of your control.' The comment I am concerned about states 'I intend to ask my patient what she thinks of that statement'. In my opinion it is inappropriate to draw a patient into internal DHB discussions.

…

In conclusion, it is my opinion that the care and information provided to [Mrs A] were both appropriate and adequate. Actions taken by Nelson Marlborough District Health Board were also appropriate considering the guidelines established by the Ministry of Health."

Appendix 3

Further expert advice was obtained from Otolaryngologist Dr Catherine Ferguson:

> "You have asked me initially on the appropriateness of ENT prioritisation of the MRI scan as 'semi-urgent' on 4 December 2006. I would consider this to be completely appropriate as the investigation was being ordered to exclude a specific pathology and it would certainly not be seen as urgent given the severity of symptoms.[21] However, I would comment that the symptoms of unilateral tinnitus associated with a hearing loss on an audiogram should be regarded as a vestibular schwannoma until proven otherwise.
>
> You have also asked me about the appropriateness of ENT prioritisations being downgraded by radiology to 'routine' and the process of communicating such decisions. Upon reviewing the file I can find a letter sent out on 11 May 2007 which was apparently sent to the patient, stating that the investigation could not be done. However, it does not actually state, and I could not find this in the file, that they had downgraded the prioritisation to routine from semi-urgent but that they were no longer able to provide it. It certainly might imply that they had downgraded the prioritisation to routine but it is not specifically mentioned. However, I do think that the wait of five months before this decision was made and then communicated to the patient, is unacceptable. I cannot find a copy of a letter in the file specifically addressed to [Mrs A] and would certainly have thought that this would be more appropriate than sending her a copy of a letter that was sent to the referring surgeon.
>
> Finally you have asked me to comment on the appropriateness of ENT follow-up after the MRI request was made. There is little in the notes to indicate much ENT follow-up at this point. I note that there is a letter dated 28 December 2006, from [Dr D], otolaryngologist, to [the] District Manager of Surgical Services at Nelson Hospital, expressing concerns about the lack of MRI availability for patients such as [Mrs A] and this was obviously a problem that was well recognised in the ENT Department at Nelson at the time. I expect that at this point the ENT surgeons in general felt that they could not get much further with the Radiology Department. However, I cannot find anything in the record to indicate what [Dr B] did about the advice that he got from the Radiology Department. I note that it was sent to him at Nelson Hospital when in fact the patient had been referred through his private rooms and as such he may not have sighted the letter, although I have no evidence either way. It is certainly apparent that no alternative investigations were suggested until she was referred back again in April 2008. At that point it was not evident from the referral letter that her symptoms were any worse and so a prioritisation of the letter within 3–6 months seems appropriate but then there was a follow-up letter written by her General Practitioner in June 2008 asking for

[21] Dr Ferguson subsequently clarified that Mrs A's additional symptoms, in particular her vertigo and loss of balance warranted the higher prioritisation by Dr B in this case.

a more urgent appointment. She was then in fact seen within two months which would seem appropriate."

Appendix 4

The following expert advice was obtained by NMDHB from radiologist Dr Sharyn MacDonald:

> "The specific matters that I have been instructed to provide an opinion on are as follows:
>
> 1. The time it took for the DHB, through its Radiology Department, to advise [Dr B], and the patient, about the ability for her to receive a publicly funded MRI. Taking into account the context, including but not limited to the introduction of a MRI scanner at Nelson Hospital at the relevant time and the demand on that service, and the patient's symptoms, please provide your opinion as to whether the timeliness of the advice from the Department to [Dr B] on 11 May 2007 was reasonable and consistent with the standards expected from comparable radiology departments in public hospitals in New Zealand.
>
> 2. The adequacy of advice provided by the Radiology Department to [Dr B] and the patient about the management options and the risks of not having a timely MRI scan. Please provide your opinion as to whether the advice provided to [Dr B] and the patient was reasonable, and consistent with the standards expected from comparable radiology departments in public hospitals in New Zealand. Whilst it is a matter for you, this will include consideration of the different roles and responsibilities of a diagnostic service and the surgeon responsible for the management of a patient, and an analysis of whether the responsibility for discussing treatment options and on-going management of a patient where a diagnostic service is not available should rest with the diagnostic service or with the surgeon.
>
> 3. Your opinion on the implications for radiology departments and other diagnostic services if the Commissioner's provisional opinion that the diagnostic service must provide advice about on-going management options stands.
>
> I have been provided with the following documents as background information:
>
> (i) The Commissioner's provisional opinion, including the reports of two experts instructed by the Commissioner; Dr Ferguson and Dr Murdoch.
>
> (ii) The patient's complaint to the DHB and the DHB's response.
>
> (iii) The Radiology Department's letter to [Dr B] dated 11 May 2007.
>
> Without discussing the specifics of this case, I have also consulted with Radiology colleagues from Auckland Hospital, Middlemore Hospital, North Shore Hospital, Hutt Hospital and Dunedin Hospital with respect to their waiting list management processes. Of note:

None were aware of any standards directly applicable to the management of diagnostic radiology waiting lists, including the requirements outlined in the Commissioner's provisional opinion to notify patients or to meet the demand for diagnostic services within 6 months, although several indicated a developing trend to using 6-months, similar to the elective services guideline, as a cut-off for declining or returning referrals.

The existence and size of waiting lists, and monitoring of waiting lists is variable, as are the processes applied to triaging and managing Radiology waiting lists, including notification of either clinicians or patients of projected waiting times.

It is regarded as appropriate for Radiologists, with their greater knowledge of the full spectrum of patients referred for imaging to, on the basis of the clinical details provided, triage at variance to that indicated by referring clinicians in order to ensure fairness and consistency of triage across all patients referred to radiology, on the understanding that a clinician may re-refer or provide additional information if the clinical situation changes.

Where referrals had been returned because demand for the requested imaging could not be met after patients had been waiting for some time, these were typically accompanied by a generic form notifying the referrer of this, with the expectation being that this would prompt clinical review of the case, and subsequent re-referral or alternative investigation and management as appropriate. Generally, only the referrers are notified.

None of the departments are currently providing patient/referral specific management advice, with all indicating that an obligation to do so would be onerous given the number of referrals involved, and potentially beyond the scope of their department's available skills and resources.

Taking into account the above my opinions are as follows:

1. The time it took for the DHB, through its Radiology Department, to advise [Dr B], and the patient, about the ability for her to receive a publicly funded MRI.

It is an unfortunate reality for DHB radiology services that demand for imaging is often greater than capacity, and that this mismatch if not immediately addressed, results in the growth of waiting lists. My experience at Canterbury DHB has been that despite extensive work by data analysts and production planning engineers on development of a model that allows the equipment and staff resource required to meet clinical demand for imaging to be predicted, along with the impact on waiting lists of not having the required resource, fluctuations in both capacity and demand mean that reliably forecasting the exact waiting time for an individual patient at the time of receipt of a referral is challenging. In the absence of nationally agreed guidelines, individual DHBs faced with a demand capacity mismatch must act in a pragmatic way to ensure imaging is made available to those with the greatest clinical need.

For NMDHB commencing a new MRI service, there was no operating experience on which to base an estimate of capacity for their site, nor any historical data applicable to a locally based service to serve as a reference for reliable demand forecasting. Despite the lack of local experience, the NMDHB MRI service appears to have identified in a very short time frame that demand exceeded capacity, and was going to continue to do so, and commenced initiatives to try to increase capacity (request for additional funding), and manage demand (working with clinicians to determine clinical priorities for scanning). The steps the MRI management group and NMDHB undertook to address its demand-capacity mismatch were reasonable given the circumstances, and in keeping with those that would be, and are employed in other DHBs.

In the context of a referral for an MRI submitted to NMDHB in December 2006 and triaged as routine and subsequently not able to be performed (consistent with the recommendations of the MMG and the group of senior clinicians who met to determine the clinical priorities for scanning), I do not think the delay in the return of the referral until May 2007 is unreasonable.

2. The adequacy of advice provided by the Radiology Department to [Dr B] and the patient about the management options and the risks of not having a timely MRI scan.

Radiology Departments are conscious of Right 6 of the HDC code but unlike clinicians who manage the individual patient, Radiology keeps patients informed via the referring clinician. A Radiology department can advise the clinician of time frames but it would be inappropriate to offer advice on specific alternative options or treatment plans as these are outside the scope of Radiology practise.

In my opinion the advice provided by the NMDHB Radiology Department to [Dr B] and [Mrs A] was appropriate for its intended purpose of communicating that on the basis of the information provided on the referral form and subsequently assigned triage category, the requested examination could not be undertaken due to demand for imaging of more urgent cases. I believe that this action was consistent with Right 6 of the HDC code. The letter indicates that other appropriate ways of investigation may be available and these alternatives should be reviewed. The generic as opposed to patient specific content of the letter is in keeping with that used by Canterbury DHB Radiology, and by other DHB Radiology departments for similar purposes.

With regard to whether this letter should have included more specific recommendations about management options and risks; in my opinion that would have been inappropriate, particularly in the context of the patient having been referred by a vocationally registered specialist. The Medical Council of New Zealand defines the scope of practise for diagnostic and interventional radiology as 'the diagnosis and treatment of patients *utilising imaging modalities*'. Detailed knowledge of clinical symptoms and examination findings, non-imaging investigations, management options, and risks and outcome data related to

different options, is beyond the scope of training of a diagnostic radiologist. For the purposes of determining whether or not imaging is appropriate and with what level of urgency it should be carried out, Radiologists are dependent on the assessment of referring clinicians, which is typically communicated via a summary of the relevant clinical details on a referral form. Clinic letters and clinical notes detailing the specialist assessment are not routinely available or sought in the context of providing diagnostic imaging services, nor is review of the patient undertaken.

It is the referring clinician's responsibility to manage the patient's clinical condition and Radiology's responsibility to advise the clinician about the availability and time frames for their requested imaging. The expectation of Radiology is that if the imaging is unable to be provided (as in this case) the referring clinician would reassess the patient and notify the radiology department if the clinical circumstances had changed and re-refer if appropriate.

3. My opinion on the implications for radiology departments and other diagnostic services if the Commissioner's provisional opinion that the diagnostic service must provide advice about on-going management options stands.

In my opinion, requiring diagnostic radiology services to provide advice about management options and the risks of not receiving timely imaging would be inappropriate as discussed above. Provision of such specific clinical advice falls outside of the scope of practise and experience of radiologists. There is risk that attempting to provide such information would result in advice that contradicts or is inconsistent with that which has been, or would be provided by the referrer. In order to ensure that any advice given is appropriate, in keeping with current clinical practise, and does not contradict and cause confusion, it is very likely that radiology departments would need to involve colleagues from other specialties, preferably those caring for the individual patients concerned. In reality, the most expeditious way of achieving this is via the approach currently employed by most departments ie notifying individual referrers that their referrals cannot be accommodated due to lack of capacity, with the reasonable expectation then being that the referrer will take responsibility for the reassessment and provision of advice relating to management options and risks to the patients for whom they are caring.

This opinion has been prepared in consultation with Professor Timothy Buckenham, Professor of Radiology, Christchurch Clinical School of Medicine."