General Practitioner

Report on Opinion - Case 98HDC12303

Complaint

The Commissioner received a complaint from the complainant about the services provided to her late husband, the consumer, from the general practitioner. The complaint is that:

- *During a weekend in early September 1997, the consumer's condition worsened and he suffered much pain. His own doctor was overseas and the general practitioner was the duty doctor in his home town. The general practitioner did not provide services of an appropriate standard.*
- *Following a suggestion that the consumer may be morphine insensitive and that alternative pain relief may be necessary, as detailed in the palliative care guidelines, the general practitioner did not allow an Oncology Nurse to contact the second public hospital's Oncology Unit Registrar for advice.*
- *On a date in early September 1997, the general practitioner did not prescribe Hypnovel for pain relief as advised by the second public hospital's Oncology Unit Registrar.*
- *On the same day in September 1997, the general practitioner increased the morphine and said he would return that afternoon to put in an IV luer. The general practitioner did not return.*
- *On the afternoon of this day September 1997 the District Nurse left a message with the Practice Nurse at the general practitioner's surgery that an IV luer was required urgently. The general practitioner did not respond to this message.*
- *On the following day in early September 1997, the complainant phoned the general practitioner asking him to come, saying she could not control her husband. The general practitioner said "leave it to me". The complainant thought this meant he would visit her home. The general practitioner did not visit the consumer.*
- *On the next day the general practitioner was again telephoned by the District Nurse who asked for Hypnovel to be prescribed. The general practitioner refused.*

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Investigation

The Commissioner received the complaint from an Advocacy Service on 19 February 1998 and an investigation was undertaken. Information was received from:

The Complainant/the Consumer's Wife
The Provider/General Practitioner
The First Oncology Nurse
The First District Nurse
The Second District Nurse
The Palliative Care Nurse
The Second Oncology Nurse
A Representative of the Town's Independent Nursing Services

The consumer's medical records were obtained from the first public hospital and the second general practitioner. The reference, *A Guide to Palliative Care in New Zealand* (1995) was obtained. The Commissioner also sought the advice of an independent general practitioner.

Information Gathered During Investigation

In December 1995 the consumer was diagnosed with cancer of the bowel. By 1997 the consumer's cancer was considered terminal and as the disease progressed he began to suffer from severe pain. During the course of his illness the consumer was nursed at home by his wife with the support of an oncology nurse at the first public hospital, the first oncology nurse, and a district nurse, the first district nurse. It was decided that the consumer would be more comfortable if he remained at home with his family. The consumer and his wife were assured that medical care and adequate pain relief would be provided. The second general practitioner (the consumer's general practitioner) and the other doctors, including the third general practitioner, at the medical centre managed the consumer's medication to keep him comfortable.

The consumer's pain was managed with several drugs, which included *morphine* administered by a subcutaneous pump injection ("S/C"). The consumer's drug regime was prescribed by a standing order. A standing order gives the administering nurse the discretion to increase the dose of medication up to a certain limit without notifying a doctor. Standing orders were kept with the morphine pump at the consumer's home.

Continued on next page

General Practitioner

Report on Opinion - Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

The consumer's standing order for early August 1997, prescribed by the third general practitioner was:

"Morphine 100 – 200mg
Maxolon 10 – 30mg
Buscopan 10 – 20mg
Dexamethasone 4 – 8 mg
Haloperidol 2 – 5mg"

These drugs were mixed in the syringe and administered S/C over 24 hours. The Palliative Care Guidelines warn against administering *diazepam* (*valium*) by subcutaneous pump injection.

In the weeks leading up to the consumer's death the amount of *morphine* administered was as follows:

Four days in mid-August *morphine*	100mg S/C daily
Eight days mid to late August *morphine*	120mg S/C daily
Up to early September *morphine*	150mg S/C daily

On a date in early September, following a telephone conversation with the third general practitioner, the consumer's *morphine* was increased to 180mg at 5.00pm and an additional 60mg was added at 8.00pm.

On the evening of the following day the consumer's pain worsened. The first district nurse telephoned the first oncology nurse who spoke with the practice nurse at the medical centre. The first district nurse's records stated:

> *"*[Date in early]*/9/97* [the consumer] *remains agitated and up to PU +++. During the afternoon required restraining by male family members. Phone call from* [consumer's wife] *requesting assistance.* [The first oncology nurse] *notified who contacted Practice Nurse. PR Stesolid* [diazepam per-rectal preparation] *attempted but too painful to administer. IM diazepam given with good effect. This was repeated at 21.30* [9.30pm]. *Morphine syringe reloaded with 360mg morphine today. Will visit later."*

During the weekend in early September 1997 the second general practitioner was overseas. The general practitioner assumed responsibility for the consumer's care as he was the duty doctor in the town.

Continued on next page

Report on Opinion - Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

On the following day the consumer was in considerable pain when visited by the first district nurse. The first district nurse advised the Commissioner that she contacted the first oncology nurse to ask for advice. The first oncology nurse advised the Commissioner that she telephoned the general practitioner and asked him to visit the consumer's home. The first oncology nurse also suggested to the general practitioner that the consumer was becoming *morphine* insensitive and that alternative medication might be necessary. She suggested that he consult the medication protocol as detailed in the palliative care guidelines. The first oncology nurse also asked the general practitioner if he wished her to phone the oncology registrar at the second public hospital oncology unit for further advice. The general practitioner informed the first oncology nurse that this was not necessary because he would assess the consumer personally when he visited the consumer's home. The general practitioner advised the Commissioner:

> *"At 0830hrs* [8.30am] *I was telephoned by DN* [the first oncology nurse] *from* [another town] *who told me that* [the consumer] *was possibly Morphine intolerant and that she could call the* [second public hospital's] *Registrar. I suggested that she should wait until I assessed the patient. She agreed and she suggested that 'Hypnovel' was the drug of choice in treating Morphine intolerance as it had an analgesic affect and enhanced the effect of Morphine this is contrary to my understanding."*

The first oncology nurse contacted the oncology registrar who agreed that the consumer could have become *morphine* insensitive and recommended that *hypnovel* be added to the medications in the pump to enhance the effect of the *morphine*. He also informed the first oncology nurse that if the general practitioner needed any guidance he would be pleased to help. The first oncology nurse telephoned the first district nurse and asked her to convey this message to the general practitioner when he arrived at the consumer's home later that day.

Continued on next page

General Practitioner

Report on Opinion - Case 98HDC12303, continued

Information Gathered During Investigation, ***continued***

The general practitioner advised the Commissioner that:

> *"At 0900hrs* [9.00am on a Saturday in early September] *I visited* [the consumer]*, he was alert, orientated and talking normally. His only complaint was non specific pain. I noted the regime of pain relief and sedation that had been used. It was very hard to follow the notes and drug regime. In order to test the theory of Morphine intolerance and to establish his quantitative need for Morphine I wrote a regime to be followed that stated:*
>
> "[Date in early]*/9/97 pain big problem put 480mg Morphine in pump. Use 10, 20, 50mg Morphine IM* [intramuscular ("IM")] *as needed for pain relief. Use diazapam 10mg IM when pain relief adequate."*
>
> *In my opinion the use of diazepam was less than desirable but it was the drug that had been chosen by* [the third general practitioner] *and he must have had his reasons for this."*

The general practitioner continued:

> *"…As far as I was aware this regime was followed with good effect. I had stated Diazepam was not to be used until pain was under control, it was given at 11:15 after the second of 350mg Morphine injections, hence if my instructions were followed he was pain free one and a half hours after I saw him. Another dose of 50mg of Morphine was given at 12:00 and no other injections given until Diazepam at 2000hrs* [8.00pm] *then 30mg of Morphine at 0030hrs. This assessment and treatment regime was based on my experience and also on my having studied the Guide to Palliative Care. On page 4 the recommended increase in dose of Morphine is 25% of the previous dose in this case around 150mg.*
>
> *On page 17 Morphine intolerance is covered and* [the consumer] *at that stage did not demonstrate any of the classical signs of this rare syndrome also there is no mention of Hypnovel as a treatment of this condition. Indeed the only mention of Hypnovel in the whole guide is on page 11 where it is mentioned as a method of control of confusion from cerebral tumours and/or secondaries a situation of which to my knowledge* [the consumer] *was not suffering from.*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

Further it was the general practitioner's opinion:

> *"…*[a]*s the medical practitioner at the scene that hypnovel would not have been useful at that time as it is not an analgesic drug and that an increase in his Morphine levels was what was necessary as this is a strong analgesic. I may add that* [the consumer] *was already receiving IM diazepam which is a similar class of drug to hypnovel.*
>
> *On assessing of the patient I found the problem was PAIN, not sedation. I recharted the pain medication increasing* [the consumer's] *Morphine via his pump and giving instructions for the use of IM supplements of Morphine until his pain was under control. I also continued the Diazepam IM to supplement sedation.*

The complainant recalled that when the general practitioner visited their home on the morning in question her husband was drifting off to sleep for about ten minutes or so. He was sedated but was being woken from his sedation by pain. The consumer asked the general practitioner to give him something to ease his pain. The first district nurse relayed the first oncology nurse's message about obtaining advice from the oncology registrar.

The first district nurse asked the general practitioner for advice about the medication if the pain should become uncontrollable again. The general practitioner advised her to continue to increase the dosage of *morphine* until the pain was controlled. The complainant confirmed this conversation. The general practitioner advised the Commissioner that he intended that any increase be within the guidelines he prescribed.

The first district nurse documented:

> *"*[Date in early]*/9/97 Phone call from* [the complainant] *at 0700* [am]*–* [the consumer] *once more agitated and in pain. Diazepam 10mg IM given at 0830* [am] *verbal order pp* [the general practitioner]*. Medication documentation and administration times at the* [the consumer's] *house. V/B* [the general practitioner] *this am at family's request. To give up to Morphine 50mg till pain controlled and Diazepam 10mg for agitation when pain controlled. Family upset +++ and not happy about* [the consumer's] *discomfort.*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

The first district nurse asked the general practitioner to insert an IV luer because the consumer was having IM injections every hour which is very painful and added to his discomfort. The general practitioner said that he would return in the afternoon to insert the luer. The complainant confirmed this conversation. The general practitioner did not return to insert the luer. The general practitioner advised the Commissioner that:

> *"...At 1030hrs* [10.30am] *I had left the* [the consumer's] *house and gone to my surgery and was in the middle of seeing a large number of people when my practice nurse told me that* [the first district nurse] *was on the phone. I was unable to talk to her at that time and suggested the nurse tell her to proceed with the treatment protocol that I had written in the notes".*

Further:

> *"...I am sure that I would not have agreed to put in an IV luer, I would not give IV pain relief and sedation to a patient in this situation as the response to IV analgesics is very short lived and in this mans condition could easily have precipitated respiratory depression and arrest.*

Despite the medication the consumer became very agitated with intense pain. His medical notes indicated, "[f]*requent IM analgesia required to get pain & agitation under control."*

The consumer's medication record indicated that he received:

> *"*[Date in early]*/9/97 50mg IM Morphine given as per* [the general practitioner's] *order – 0950* [9.50am]
> *0830* [8.30am] *Diazepam 10mg IM given.*
> *1100* [11.00am] *50mg IM Morphine given.*
> *1115* [11.15am] *10mg Diazepam IM given.*
> *1200* [12.00pm] *50mg IM Morphine given.*
> *2000* [10.00pm] *Diazepam 10mg."*

The general practitioner reported that:

> *"At 1500hrs* [3.00pm] [the first district nurse] *was working an afternoon shift at* [the third public] *Hospital. That afternoon when I spoke to her and asked her how* [the consumer] *was she told me he was doing well and that his pain was controlled, at this stage I was happy that my assessment had been correct and that my treatment had been totally correct."*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

The first oncology nurse remained concerned about the pain regime prescribed by the general practitioner and his reluctance to telephone the oncology team at the second hospital for further advice. In the afternoon she tried to contact two other doctors about her concerns and to have a different regime prescribed but neither was at home.

The first oncology nurse advised the Commissioner that she had a number of concerns about the drug regimes prescribed by the general practitioner. She said that the way pain medication is administered produces a peak and trough affect. If *morphine* and *diazepam* are used as a method of pain control the patient will initially be quiet and sedated. However the pain will break-through this barrier and come back stronger. This is not a good way to manage pain. On the other hand with continuous S/C *morphine* the patient's pain is prevented from becoming severe. The aim is to have the pain evenly controlled and avoid this peak and trough effect.

Furthermore *hypnovel* can be administered S/C in the pump and this saves the discomfort of frequent IM injections. *Hyonovel* enhances the effect of *morphine*. The consumer was later given *hypnovel* and he became peaceful and pain free. This demonstrates the combined effect of the drugs. It is also a good problem solving approach to controlling pain. If the patient is an intense pain and the pain cannot be controlled with one form of medication it is advisable to look for alternative solutions.

The first oncology nurse referred the Commissioner to page eleven of the protocol *A Guide to Palliative Care in New Zealand* where it is recommended that *hypnovel* (*midazolam* is no longer available) is added to the medication regimen when *morphine* is no longer effective and the patient is agitated.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, ***continued***

The nursing notes for the date in early September 1997 further indicated:

> *"*[Date in early]*/9/97 Dr asked this am to provide IV access to eliminate need for IM injections.* [The general practitioner] *said that would be acceptable. Urinalysis trace of protein/nil else. Frequent IM analgesia required to get pain and agitation under control. (Documentation at the house) Family requesting sedation to be utilised to keep* [the consumer] *comfortable. 460mg Morphine put in syringe driver today/other meds -*
> *Maxolon 20mg*
> *Dexamethasone 4mg*
> *Haloperidol 10mg*
> *Buscopan 20mg*
> *Na Cl 17mls in 20 ml syringe/15 mls of med/2mls Na Cl*
> [The consumer] *became restless and agitated early evening. Further Diazapam 10mg given by* [the second district nurse] *in my absence (at 2000 hrs)* [8.00pm]*."*

The second district nurse advised the Commissioner that the consumer was comfortable when she visited on the Saturday evening (in early September 1997). She gave the *diazepam* as a precautionary measure because she had spoken with the first district nurse and was aware of the consumer's history of pain over the last few days. She was prepared to stay the night if needed but she did not consider this necessary. In a letter of 4 September 1998 to the Commissioner the second district nurse stated:

> *"To whom it may concern*
> *This is a record of my last two visits as district-nurse to* [the consumer] *of* [address in town].
> *On* [a date in early] *September 1997 in the evening I attended* [the consumer] *to administer intramuscular Diazepam per* [the general practitioner's] *written orders. At this time* [the consumer's] *pain appeared to be controlled and his agitation settled."*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

The first district nurse advised the Commissioner that:

> *"The history of the patient indicated that the Valium* [Diazepam] *was effective in keeping* [the consumer] *relaxed, and the family were frightened and anxious that they were going to relive what they had already been through. The previous day he had been so agitated that he had to be restrained by male family members. My documentation stated that "*[the consumer] *became agitated and restless early evening" on the* [date in early]*/9/97, so in keeping with the family's wishes, I felt that it was justified, so I advised* [the second district nurse] *to administer it."*

The first district nurse visited the consumer when she completed her duty that night. The consumer's notes continued:

> "[Date in early September 1997] *2330* [11.30pm] *comfortable and sedated when visited. Syringe driver reloaded with 600mg Morphine. 30mg IM Morphine given at same time.*

The general practitioner questioned the need to increase the amount of *morphine* in the syringe to 600mg, outside his specific instruction, when the consumer was comfortable and sedated.

The first district nurse advised:

> *"The increased dose of Morphine from 480mg to 600mg was drawn up for* [the complainant] *to insert in the syringe driver when the one containing 480mg had run through. Because she was depressing the bolus button frequently, the medication in the syringe driver would have run through in less than the 24 hr set rate period. She had been instructed on how to change the syringes over, and was competent in the procedure."*

The complainant advised the Commissioner that she recalled that her husband's pain became uncontrollable in the late hours of Saturday night or the early hours of Sunday morning. She thought that the consumer might die. After being administered valium at 8.00pm that evening, his respiration became very irregular and he seemed to be gasping. The complainant was not certain of the time but thought it was probably around 11.00pm and all of the family was present. Then the consumer fell asleep.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, ***continued***

In the early hours of Sunday morning the consumer's pain became very intense. The complainant rang the general practitioner at about midmorning. She was very upset and crying. She advised the Commissioner that she begged and pleaded with the general practitioner to come to see her husband because she wanted him to see the consumer when he was in acute pain. The general practitioner said to her *"leave it to me"*. The complainant understood that to mean he would come around to see the consumer but he did not arrive.

The general practitioner advised the Commissioner that when he said *"leave it to me"* the complainant misunderstood him. He intended to ask the district nurse to visit and assess the situation. The first district nurse was uncertain whether the general practitioner rang her on Sunday morning or whether she went around to visit the consumer because she was going to see him anyway. The general practitioner confirmed he rang the first district nurse because in his view the complainant was hysterical and he needed an objective assessment of the consumer's condition. The complainant and the first district nurse waited for the general practitioner to arrive. When he did not come the first district nurse rang the clinic but the practice nurse did not put her through to the general practitioner. The general practitioner said that when he did not hear from the first district nurse he assumed the consumer's pain was controlled.

The general practitioner advised the Commissioner that to his knowledge:

> *"During* [the day when the general practitioner had been telephoned in the early hours of the morning and the following day the consumer] *received no extra diazepam or Morphine from the district nurses until diazepam was given at 7.30am on* [the following day]*."*

The consumer's records indicated that the amount of *morphine* administered S/C to the consumer increased from one syringe a day on the date on which the third general practitioner changed the dosages in early September 1997 as follows:

The following day S/C *morphine* 270mg 9.30am and 360mg 8.45pm
The day the general practitioner took over S/C *morphine* 480mg 11.45am 600mg 12mn.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, ***continued***

The consumer's records confirmed his total *morphine* increase on the day after the general practitioner assumed responsibility:

> "[The day after the general practitioner assumed responsibility]*/9/97 0030* [12.30am] *Morphine 30mg IM given.*
> [The same day]*/9/97 1130* [11.30am] *pump reloaded - 960mg Morphine – resited.*
> *2300* [11.00pm]*– pump reloaded – 960mg Morphine.*
>
> [The same day]*/9/97 had a peaceful night.* [The complainant] *using bolus button ++. Syringe driver reloaded at 1100* [11.00am] *with 960mg Morphine, Maxolon 10mg, Dex. 4mg, Haloperidol 5mg and Buscopan 20mg. No IM medication given today. Has had a good day but also has muscle twitching. Oral mucosa much improved. Still Puing and passing faeces in small amounts but not getting up now.*
>
> *2230* [10.30pm] *syringe driver reloaded as this morning will visit early am. 02* [oxygen] *2Lts.*

The general practitioner questioned why the *morphine* was increased when the records showed that the consumer was peaceful. He advised the Commissioner that he was unaware of the amount of *morphine* the consumer was receiving and that any administration over 480mg was outside his specific instruction and should not have been given without consulting him. The general practitioner was not contacted. The first district nurse answered that:

> *"The Morphine was increased to allow for anticipated pain relief requirements.* [The consumer] *had used the 960mg Morphine up in 12 hours, (from 1100 hrs to 2300 hrs* [11.00am to 11.00pm]*) which necessitated a further one* [pump] *to be refilled at 2300 hrs* [11.00pm]. *Under normal circumstances, it would have lasted 24 hours.*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

I also increased it because he was extremely distressed, attempting to tear his clothes off and stamping his feet. His family were unable to stop him from getting out of bed, even at this stage of his dying process. [The complainant] *was unable to control him, and she remembers* [the consumer] *pushing her out of the way.* [The complainant] *phoned* [the general practitioner] *mid-morning and relayed to him the behaviours I have just described. I was not put through to him at the Clinic on Sunday morning when I was wanting further management instructions, so I followed the verbal statement he had made the previous day on his house call, which was to keep increasing the Morphine until he* [the consumer] *was comfortable. From 1135 until 2300* [the consumer] *had used 960mgs of Morphine."*

The general practitioner noted that:

> *"*[On the third day that the consumer was being managed by the general *practitioner]07/97*
> *On the […] morning I was called between 07-30 and 08-30 by [the first district nurse] who was again wanting me to prescribe* Hypnovel. *I was angry with her as she was not being very objective and she seemed fixated on giving* [the consumer] *Hypnovel."*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

In the consumer's notes, the first district nurse recorded on the same date:

> "[… The complainant] *phoned me at* [the third hospital] *at 06.00* [am] *and said* [the consumer] *had a terrible night, yelling out and throwing his arms about. I instructed her to give S/L Ativan and I would get there ASAP. On arrival at the house* [the consumer] *was groaning and had some jerking muscular movements in his arms. Diazepam 10mg IM administered at 7.30am. I was asked by* [the complainant] *when she spoke to me on the phone earlier if Hynovel could be added to the pump that morning as she knew the advantages of it when she spoke with our Oncology Nurse earlier on. I telephoned the on-call duty* [Dr] [the general practitioner] *at 7.30 and informed him of* [the consumer's] *present condition. I asked him if I could include Hypnovel today as* [the complainant] *had requested. He immediately became angry and said "What the bloody hell does* [the complainant] *know about Hypnovel who's been talking to her about it." He continued in this manner throughout the conversation and then said "I'm bloody sick of people dropping drug names past me" or words to that effect. There was only 720mg of morphine left at the house to refill the syringe – went to Pharmacy to collect a further 240mg shortly after 0800.* [The first oncology nurse] *happened to phone the house while I was there and I told her what* [the general practitioner] *had just said to me …"*

The second district nurse reported:

> *"*[On the same day]*/9/97 Along with* [the first district nurse] *I attended* [the consumer]. [The consumer] *appears minimally responsive now. Family stated he had been restless <u>at times</u>* [the complainant] *and helpers tired and anxious.* [The second district nurse]*."*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

The first district nurse further recorded that:

> *"My attempts at working with* [the general practitioner] *over the weekend to give* [the consumer] *adequate pain control and place less strain on his already traumatised wife have been extremely difficult. The IV access which I asked for was not* inserted *and* [the consumer] *required repeated IM analgesia, in addition to the large sub-cutaneous content of Morphine.* [The complainant] *wished to speak to him* [the general practitioner] *on the phone while he was at the clinic on Saturday morning but he wouldn't speak to her. I then rang wishing to speak with him but he wouldn't speak to me either. The Practice Nurse said he told her to tell me that I had my instructions. I then told her I wanted him to insert an IV cannula and she said she'd pass the message on. I feel that* [the general practitioner] *has failed to meet the needs of my patient and his family at such an important time."*

The general practitioner advised the Commissioner that:

> *"I was at work at another doctor's surgery when rung on* [the third day]. *Hence* [the consumer's] *care was responsibility of his own GP as of 8am on a Monday morning. I informed the nurse of this and she then got in touch with the regular doctor, who attended the patient."*

The first oncology nurse advised the Commissioner that she arrived at work at the first public hospital at 7.30am on Monday morning and immediately rang the consumer's home. She was told about the conversation with the general practitioner and that the consumer was in severe pain. The first oncology nurse immediately rang the third general practitioner who was driving to work. He immediately went to the consumer's home and ordered *hypnovel*. The medication sheet indicated:

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Information Gathered During Investigation, *continued*

"[The third day after the general practitioner assumed responsibility]
/9/97 Morphine 720mg 0730
Dexameth 4mg
Serenase 5mg
Buscopan 20mg

1000 Morphine 240mg) added to
Hypnovel 30mg) syringe
Saline to 18mls)

The consumer died peacefully about one and a half hours after the *hypnovel* commenced. The complainant found that her husband's death was so difficult that she was unable to fulfil her promise to her children that they would have the opportunity to say goodbye to their father.

The general practitioner recalled:

> *"I was dumped in the middle of the situation with no prior knowledge with totally inadequate notes that suggest the patient was not seen by a doctor in the week before I saw him. The quality of the drug records was hopeless and it appears that Morphine was being administered without any written authority at all."*

Advice to the Commissioner

The Commissioner sought advice from an independent general practitioner on a number of issues.

- Was the continued severe pain the result of inadequate or inappropriate administration of *morphine* and *diazepam* as prescribed by the general practitioner?

  "[The consumer] *had extensive malignant disease with widespread intra abdominal secondary spread. It is difficult to say exactly where his pain was arising from but given the history that is available to me it is likely that he was experiencing deep visceral pain which unfortunately is not easy to control and may not respond well to Morphine or similar narcotics.*

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Advice to the Commissioner, *continued*

[The consumer's] *pain increased substantially on the day before* [the general practitioner's] *visit. It was not inappropriate to trial increasing the Morphine dose but I do not think, at these levels, it is appropriate to keep "doubling" the dose ad infinitum.*

From the records I have I do not believe that [the consumer's] *pain was responding adequately to the Morphine and that continued administration of more and more Morphine would not really have made a lot of difference.*

In this situation it would have been more appropriate to reassess the whole drug management in consultation with the Nurses and [the consumer's] *family. I do not underestimate the difficulty of a 'new' doctor being asked to come in to manage this complex situation. It is difficult to assess how much of the relevant information was relayed to* [the general practitioner].

- Should an intravenous luer have been inserted for the administration of medication and was the general practitioner's concern about respiratory arrest as well founded?
- *"I do not believe that there is position here to advocate for intravenous administration of medications, especially IV Morphine or Valium. IV administration of medication is rarely used in Hospice palliative care let alone in the home setting. Respiratory suppression and subsequent arrest could certainly be a side effect of inappropriately administered IV drugs. A second sub-cutaneous line could have been set up for the bolus administration of "as required" medications."*
- Should the general practitioner have made another visit to the consumer during the weekend?

  "As mentioned above I think this was a complex situation to manage and as such frequent and ongoing reassessment would have been essential. This can only adequately be achieved by visiting the patient and talking to all involved including the family and nurses.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Advice to the Commissioner, *continued*

In situations like this where, after adequate assessment, pain can not be controlled and the patient is in the terminal stage of their disease then one of the options for management is to sedate the patient. This appears to have been what [the consumer's] *family had expected.*

From the records it is unclear just how much of this was conveyed to [the general practitioner] *and ongoing arrangements for follow up were not specified but I think that there was sufficient concern that closer monitoring should have been undertaken by him.*

- Should the general practitioner have consulted with the oncology team as requested?

  "If [the general practitioner] *felt that he was not managing the situation well then telephone consultation with the Oncology Unit would have been appropriate. I do not believe that* [the consumer's] *last few days were managed adequately and that advice from the Oncology Unit at* [the second hospital] *may well have improved the outcome."*

My adviser concluded his assessment by stating that:

"*In summary* [the consumer] *and his family were led to understand that his death would be managed in a way that would be peaceful if not entirely pain free. This is one of the goals of Palliative Care and unfortunately was not achieved for* [the consumer]. *This was a complex case involving difficult issues of palliative care and unclear lines of communication. Having reviewed all of the information available to me it is my opinion that* [the general practitioner] *failed to adequately assess this situation and as such failed to provide* [the consumer] *with a standard of care that would be expected of a General Practitioner in his situation*."

The Commissioner discussed the principles of palliative care with the second oncology nurse from the first public hospital and a palliative care nurse from the second public hospital.

They advised that a patient can be kept pain free during the terminal stages of an illness and can be cared for at home with the support of health professionals. However, where the pain becomes too difficult to control at home hospitalisation may be necessary.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Advice to the Commissioner, *continued*

The palliative care team relies on a number of drugs to achieve pain control including *hypnovel*. *Hypnovel* can be administered subcutaneously and is used frequently in home care drug regimes.

Intramuscular injections are rarely used because they cause pain and there are more effective methods of administering drugs. *Diazepam* can be administered rectally and is called "*stesolid*".

Once the pain is under control, frequent, low dose administrations of the drugs will maintain control better than larger doses administered at longer time intervals. Initially it may be necessary to administer *morphine* intravenously to bring the pain under control.

The amount of drugs administered is not an issue but it is the effect of their administration that is important. Every patient is an individual and must be frequently assessed and drugs prescribed accordingly. If the pain is not relieved another drug regime should be tried. Some patients require large amounts of morphine. In some instances pain will not be controlled regardless of the amount of morphine given. In this case morphine must be supplemented with another drug. If there is any doubt about what drugs can be used help is available from a base hospital oncology department.

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 3
Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*
2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*

…

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

Other Standards

"A Guide to Palliative Care In New Zealand" Third edition. Dr Robert Dunlop et al. Page 11.

"MEDICATIONS FOR SUBCUTANIOUS USE WITH PUMP

1. ANALGESICS

Morphine is the anaesthetic of choice for most severe pain. Starting dose for subcutaneous use is approximately two thirds of the oral/rectal dose.

i.e. 30mg 4/hourly PO or PR is equivalent to 20mg SC in four hours or 5mg hourly.

Often the change to SC medication is necessary because of a changing situation. The amount of Morphine will probably need adjusting upwards and, therefore, consideration should be given to using the same dose SC as oral/rectal dose.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Other Standards, *continued*

Morphine for SC use is available in the following concentrations:

(a) ***Morphine Sulphate***	*10mg/mL*
	15mg/mL
	30mg/mL
b) ***Morphine Tartrate***	*120mg/1.5mL (80mg/mL)*

3. SEDATION

e.g. For terminal confusion/agitation (e.g. cerebral tumours or metastases), flunitrazepam 1/5mg/hr (or midazolam) can be given SC. (Hypnovel used now instead of Midazolam).

NB: do not give chlorpromazine/diazepam/prochlorperazine SC.

A Guide to Palliative Care in New Zealand, Page 12 states:

MORPHINE INSENSITIVE PAIN

INTRODUCTION
The majority of cancer patients experience pain, usually as a direct result of the cancer but sometimes as a result of the treatment or coexisting painful conditions.

Oral Morphine has a very important role in relieving cancer pain, particularly pain arising in involvement of:

(a) Visceral structures such as liver, pelvic organs and bowel.
(b) Deep somatic structures such as bone

The principals of Morphine therapy have been outlined in the section dealing with oral Morphine, page 2.

However, some cancer pains respond only partially or not at all to Morphine, particularly:

Continued on next page

General Practitioner

Report on Opinion - Case 98HDC12303, continued

Other Standards, *continued*

(a) Superficial somatic pain
(b) Intermittent deep somatic pain
(c) Pain from nerve destruction

Practice point: Cancer patients frequently have more than one pain. A careful pain history is essential for planning treatment.

Frequently a combination of analgesics is necessary to ensure maximum pain relief.

Practice point: suspect Morphine insensitive pain when increasing doses of Morphine fail to relieve pain.

Patients with Morphine sensitive pain will have their pain relieved by Morphine. They may require higher doses of Morphine, and sometimes even several hundred milligrams as the cancer progresses, but appropriate dose increases will restore pain relief.

In contrast, patients with Morphine insensitive pain may experience partial relief of pain when Morphine has started but dose increases never completely control the pain.

Guide to Palliative Care In New Zealand, Page 17 states:

MORPHINE INTOLERANCE

True morphine intolerance is rare and occurs in about 5% of patients. The symptoms are:

a) Persistent vomiting despite adequate regular doses of antiemetics, despite subcutaneous administration of morphine.
b) Drowiness which persists several days after initiating morphine despite adequate dose titration and where the patient is not obviously dying.
c) Confusion and hallucinations/delusions not attributable to other causes such as hypercalcaemia or terminal agitation. If morphine therapy is the case, patients will usually have generalised twitching and myoclonic jerking as well.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Other Standards, ***continued***

A Guide to Palliative Care In New Zealand, Page 2 states:

THE ANALGESIC LADDER

This provides a logical sequence for the use of analgesics, beginning with non-opioid analgesics and moving in a stepwise fashion as the patient's disease progresses.

If an analgesic fails to relieve pain at its maximum dose, proceed to the next step, don't move sideways in the same efficiency group.

Lower run:	*Paracetamol, Aspirin or Nsaid.*
Second run:	*Panadeine, Di-gesic or DHC continuous.*
Third run:	*immediate release Morphine, Tablets or mixture to Titrate.*
Fourth run:	*MST continous.*

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Opinion: Breach

In my opinion the general practitioner breached Right 3, Right 4(1), Right 4(2), Right 4(3) and Right 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Rights 4(1) and 4(2)

Inadequate Pain Control
The consumer began to experience severe pain in early September 1997 and was given *diazepam* and his S/C *morphine* was increased. It was therefore appropriate that the general practitioner, after visiting the consumer and assessing his pain level, continue this regime for a trial period.

The general practitioner assured himself on the afternoon of the day he took responsibility that the consumer's pain was controlled and said that he was unaware that the consumer was suffering pain after that time. I do not accept that. The complainant phoned him on the following morning and asked him to visit because she wanted the general practitioner to see her husband when he was in acute pain. The general practitioner's own recollections were that the complainant was hysterical. The first district nurse phoned him on the morning of the next day because she knew the consumer's pain was uncontrolled.

The general practitioner questioned the need to increase *morphine* when the consumer was comfortable. The amount of *morphine* administered markedly increased from early September 1997. The consumer was not comfortable with continuous administration of increasing amounts of *morphine*. It seems that the first district nurse had two means of pain control at her disposal; IM *morphine* and *diazepam* and S/C *morphine*. I am advised and accept that repeated IM injections are a painful, unnecessary and inadequate method of bringing pain under control and keeping it under control. It could be that the consumer suffered an exacerbation of his disease in the days leading up to that weekend. The general practitioner was the only one who could have re-assessed the consumer and prescribed new treatment and his failure to do so was a breach of the Code of Rights.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Opinion: Breach, *continued*

Failure to Provide Ongoing Assessment

The general practitioner received a telephone call from the first district nurse before 8.00am on the third morning after he had assumed responsibility for the consumer. I do not accept that the consumer was no longer the general practitioner's concern. The first district nurse recorded the events of that morning soon after the consumer died. The general practitioner did not respond appropriately to calls from the complainant and the first district nurse over that weekend. His failure to respond appropriately did not meet his fundamental duty to provide services with reasonable care and skill as required by Right 4(1) of the Code.

If the general practitioner was aware that the complainant was hysterical he should have followed up. Further if the general practitioner had any concerns about the care being provided by the first district nurse or the complainant he had an additional responsibility to personally satisfy himself that all was well. In my opinion this could only be achieved by either following up by telephone or a further visit.

Right 4(3)

Care Consistent with Needs

The general practitioner has advised me that in his clinical opinion the consumer did not show signs of *morphine* intolerance and I can find no evidence that would cause me to doubt his assessment. However there is evidence that the consumer may have been becoming *morphine* insensitive and this was the view of the nurses tending him at that time. The Palliative Care Guidelines indicate the differences between intolerance and insensitivity. In my opinion the general practitioner did not turn his mind to the possibility of insensitivity. In failing to do so the general practitioner did not provide services to the consumer that met his need for appropriate pain relief.

The general practitioner was reluctant to prescribe *hyponovel* because in his view it was too dangerous and not used in the home situation. The Palliative Care Guidelines advise that the drug of choice for the treatment of agitation is midazolam (*hypnovel*). The consumer's notes recorded his agitation for several days before he was seen by the general practitioner. *Hypnovel* has the added advantage that it can be given in the subcutaneous pump with *morphine* and saves the need for intramuscular injections. The general practitioner, as a general practitioner, may have been unfamiliar with palliative care drug regimes but he failed to take steps to ensure appropriate medication was ordered and this failure was a breach of the Code.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Opinion: Breach, *continued*

Right 4(5)

Failure to Co-ordinate Services
The team looking after the consumer included his wife, oncology services, doctors at the medical centre and district nursing services. The medical centre's medical staff were unavailable over the weekend and the general practitioner needed to co-ordinate with what remained of that team. The general practitioner did not trust the advice he received from the first oncology nurse, nor information from the first district nurse or the complainant and did not agree with the third general practitioner prescribing *valium*.

The general practitioner could have referred to several professional sources for information on pain control management. He could have listened to the first oncology nurse who advised him that the consumer's pain may becoming insensitive to *morphine* and requested that he consider the addition of *hypnovel* to the drug regimen. The first oncology nurse has considerable experience and education in pain management. Further the general practitioner could have telephoned the oncology registrar at the second hospital to discuss pain management. The general practitioner chose to do none of these things. In my opinion the general practitioner's failure to consult with other members of the health team including the complainant, in a situation where the consumer's pain was so clearly uncontrolled was a breach of the consumer's right to quality and consistent care.

Both the first district nurse and the complainant confirm that the general practitioner said he would come back on the afternoon of the day he assumed responsibility for the consumer and insert an intravenous line. It appears the general practitioner later decided this was not an appropriate way to administer drugs in this instance, but he did not communicate this decision to the first district nurse and the complainant or prescribe a drug that could be administered subcutaneously. The general practitioner's failure to keep other health professionals informed was also in breach of his duty to co-ordinate with them.

Continued on next page

General Practitioner

Report on Opinion – Case 98HDC12303, continued

Opinion: Breach, *continued*

Clearly, and for whatever reason, there was a situation of mistrust between these health professionals and the consumer's rights were not met. Regardless of how the general practitioner perceived the relationship between himself and the others involved he had an obligation to ensure that this did not affect the consumer's care.

Right 3

The general practitioner also breached Right 3 of the Code as he had a duty to ensure his services allowed the consumer to end his life in a dignified manner. In my opinion this did not occur.

Actions

I recommend that the general practitioner takes the following actions:

- Apologises in writing to the complainant for his breach of her husband's rights under the Code. This letter to be sent to my office and I will forward it to the complainant.
- Reads the Code of Health and Disability Services Consumer's Rights.
- Confirms that in future he will discuss matters with other health professionals involved in his patient's care and will consider their views before he makes decisions.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand with a request that an immediate review of the general practitioner's competency occurs.

This file will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994.

This opinion will be a matter of public record.