13 March 2003

Dear Mr B

Thank you for your response on behalf of your family to my provisional opinion.

I accept that you and your family are extremely disappointed by my comments on the lack of involvement of the hospice in Mr A's care. You acknowledge that in hindsight hospice support would have been a better option, but point out that the issue was raised only a week after Mr A had been told he had terminal cancer when your family was in a state of shock and denial and unable properly to consider the matter.

It is certainly understandable that Mr A and your family did not wish to use the services of a hospice under these circumstances and I acknowledge your family's recommendation that meetings between a hospice and a consumer should not take place within two weeks after a terminal diagnosis (if time permits). However I remain of the view that the lack of involvement of the hospice meant that it was more difficult for Dr C and other staff, particularly because the provision of palliative care was outside their area of expertise, to ensure that you father received appropriate continuity of care. The standard of care provided by Dr C and staff to Mr A must be assessed in this context.

Having carefully considered your response to my provisional opinion and the information that I have gathered after a lengthy investigation, I have not been persuaded to alter my provisional no breach finding on the complaint made by your family about the services provided by the District Health Board (…) and Dr C to your father, Mr A. The reasons for my decision – which are substantially unchanged from my letter of 16 January 2003 – are set out below.

Complaint
Your complaint was summarised as follows:

District Health Board
The District Health Board did not provide the appropriate standard of health care to Mr A. In particular, it did not have in place the appropriate policies or procedures so that:

- *the referral made on 6 January 2000 by, Mr A's general practitioner, for an endoscopy appointment was lost or misplaced. Therefore, Mr A did not have this procedure until 14 March 2000;*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *when Mr A came to his pre-admission check on 27 March 2000 he was told that there was no record of his appointment;*
- *Mr A did not have contact with the pain nurse for six days after his admission on 26 July 2000, even though he admitted himself with acute pain;*

- *Dr C was informed as soon as practicable of Mr A's admission to the public hospital on 26 July 2000. Therefore, Dr C did not see Mr A until six days after his admission;*

- *Mr A's discharges from the public hospital on 3 April and 7 August 2000 were not properly planned.*

Dr C

Dr C did not provide the appropriate standard of health care to Mr A. In particular he:

- *did not advise Mr A after his gastroscopy on 14 March 2000 that he considered one of the possible diagnoses was cancer;*

- *at the appointment on 22 March 2000 he did not:*

  - *advise Mr A to bring a support person(s) with him as during this appointment Dr C informed Mr A he had inoperable cancer and two to four weeks to live;*

  - *meet with Mr A until he had been waiting for one and a half hours;*

  - *discuss options and outcomes for the treatment of Mr A's condition with him at the appointment or thereafter, except surgery intended to bypass his tumour rather than remove it. This includes not advising Mr A that the intended surgery would only extend his life by a few months so that he could make a fully informed decision as to whether or not to proceed with it;*

  - *allow Mr A enough time to recover from the shock of hearing he had a short time to live so that he could fully consider his treatment options.*

- *did not at any time after the appointment on 22 March 2000 suggest to Mr A that he meet with his family to discuss his diagnosis;*

- *did not appropriately plan Mr A's discharges on 3 April and 7 August 2000;*

- *did not prescribe appropriate anti-nausea medication to Mr A;*

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- *did not give Mr A appropriate advice by suggesting to him that he ask his general practitioner, Dr D, to prescribe Celebrex as Mr A was allergic to Non Steroidal Anti-Inflammatory Drug;*

- *did not respond for three days to Mr A's urgent telephone request to discuss his pain relief options;*

- *did not refer Mr A to an oncologist during the course of his treatment;*

- *was insensitive to Mr A, when discussing his life expectancy on 1 August 2000, by saying, "you've had a longer run than most".*

Information

During the investigation I carefully reviewed information from Mr A's family, Dr D (Mr A's general practitioner), Dr C and the District Health Board. I sought independent expert advice from Dr Stephen Kyle, a general surgeon. I enclose a copy of Dr Kyle's advice.

Chronology of events

- 6 January 2000 Mr A was referred to Dr C for a gastroscopy by his general practitioner.

- 14 March 2000 Mr A had a gastroscopy.

- 16 March 2000 Mr A had a CT scan of the abdomen.

- 22 March 2000 Mr A was seen by Dr C as an outpatient to discuss the results of his CT scan and further management.

- 28 March 2000 Mr A underwent a gastroenterostomy operation.

- 29 March 2000 Arrangements were made for visits by the hospice palliative care nurses, but unfortunately a relationship between the hospice staff and Mr A was not able to be established.

- 3 April 2000 Mr A was discharged from the public hospital.

- 6 April 2000 From this date regular outpatient reviews took place until Mr A's admission to hospital on 26 July 2000.

- 26 July 2000 Mr A was admitted to the public hospital under Dr E, surgeon.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- 7 August 2000 Mr A was discharged home.

- 23 August 2000 Mr A died.

Final Opinion

In my opinion, the District Health Board and Dr C did not breach Right 4(1) of the Code of Health and Disability Service Consumers' Rights (the Code). Right 4(1) states that every consumer has the right to have services provided with reasonable care and skill. My opinion is based on the following grounds:

District Health Board

Delay in gastroscopy
I note that the documentation provided by the DHB includes a copy of Dr D's referral for a gastroscopy. I agree with the advice of my expert advisor, Dr Kyle, that there is no documented evidence that Dr D's original referral for a gastroscopy was lost or misplaced. I also accept that the delay in Mr A having his gastroscopy was not excessive, particularly at that time of the year, and in light of the symptoms Mr A was experiencing. In this respect, I acknowledge Dr Kyle's advice that the waiting time for a semi-urgent gastroscopy can be up to 10 to 15 months in some centres in New Zealand. I further accept Dr Kyle's advice that Mr A was not compromised by this delay.

No record of pre-admission check on 27 March 2000
In relation to the absence of a recorded appointment for Mr A's pre-admission check, in my opinion further action is not warranted, for the following reasons. Although Mr A was not seen at the scheduled time of 9am, he was given a later appointment on the same day. The DHB assumed that there was a breakdown in communication between the receptionist and Mr A and has acknowledged this in correspondence with your family.

Pain nurse during hospital admission on 26 July 2000
The DHB has acknowledged that the pain nurse did not see Mr A until six days after his admission to hospital on 26 July 2000. However, I acknowledge the comments that it was not within the Acute Pain Nurse's position description to see patients who are not in the immediate surgical phase.

I accept my expert advice that the symptoms of pain and nausea in terminally ill patients are generally best dealt with by a palliative care team based in a hospice environment. Your family stated that the hospital staff arranged an appointment with the hospice too soon after the shock of your family hearing of Mr A's diagnosis. Understandably, in light of the shock and distress upon learning of Mr A's condition, your family did not wish to use the services provided by the hospice. Mr B stated that

the meeting was in "bad taste" and put his father off going to a hospice when he could have used it.

The DHB stated that where a patient is diagnosed with terminal cancer, hospital staff arrange for the patient and their family to meet hospice staff and a district palliative care nurse gets involved early on. I accept Dr Kyle's advice that the meeting arranged for your family and hospice staff was appropriate and that the hospice could have offered Mr A with the best chance of being provided with suitable care. In my opinion, given the lack of involvement of the hospice team, hospital staff did their best to manage Mr A's pain.

I further accept my expert advice that if a satisfactory relationship had been established before Mr A's discharge from hospital on 3 April 2000, the subsequent admission on 26 July 2000 could have been avoided.

Delay in consultant review of Mr A
In the days leading up to 26 July 2000 Mr A experienced further distress in relation to his pain management. Because a relationship had not been established with the hospice, Dr C had advised Mr A to either attempt to contact him at the hospital, consult his general practitioner or present to the Emergency Department. Accordingly, Mr A presented to the Emergency Department with abdominal pain.

The DHB acknowledged, in its letter dated 19 October 2000 to your family, that Mr A was admitted to the medical ward rather than the surgical ward on 26 July 2000 under Dr E. It is also acknowledged that Mr A was not seen by Dr C until 1 August 2000 although the medical records indicate that Mr A was seen by Dr E during this period.

The DHB advised me that occasionally bed management necessitates the overflow of patients from one unit to another and that while there is a process in place to inform consultants about their patients that are located outside of their designated specialty unit, the system failed in this situation. In my opinion, it was reasonable to expect that Dr C would be contacted promptly about Mr A's admission. I acknowledge that since the circumstances giving rise to this complaint, the DHB has taken steps to notify consultants of patients located in areas of the hospital other than their designated specialty unit.

Mr A's discharges from hospital
In response to my provisional opinion your family said that Mr A's discharge planning was not appropriate because the discharge list had not been completed, and in particular the district nurses were not advised of Mr A's discharge on 7 August 2000. In my opinion, the discharge planning from hospital on 3 April 2000 and 7 August 2000 was appropriate. I accept the advice of Mr Kyle that the discharges would have been optimal if a satisfactory relationship had been established with the hospice team who could have provided outpatient and inpatient care for Mr A. It appears that staff at the public hospital provided Mr A with care beyond the scope of their normal practice in an attempt to address the absence of hospice care. I accept

that this led to some omissions in the continuity of his care upon discharge. However I acknowledge Dr C's comment that Mr A was advised to present to the Emergency Department or his general practitioner if he developed further problems and that he also suggested your family contact him directly. Furthermore, Dr C reviewed Mr A on a regular outpatient basis. Although not ideal, I remain of the opinion that under the circumstances, the actions taken by Dr C and the public hospital were reasonable and do not amount to a breach of the Code.

I also acknowledge the comments made by the DHB that since the circumstances giving rise to this complaint, clinical staff at the public hospital have taken steps to improve the communication with patients during the process of discharge and have developed a revised discharge checklist that ensures the involvement of patients and family in discharge planning.

Dr C

Diagnosis of cancer

Dr C has acknowledged that he did not inform Mr A immediately after the gastroscopy on 14 March 2000 that he suspected that Mr A had cancer. I acknowledge his reasons for this:

- Mr A had been sedated
- Dr C had other hospital commitments
- Mr A had a low probability of cancer and an appointment for a CT scan was arranged
- Mr C arranged to see Mr A at the time when the results of the scan would be available.

In response to my provisional opinion your family stated that Dr C should have told Mr A of the possibility of cancer prior to having his CT scan. However I accept the advice of my expert advisor, Dr Kyle, that the task of informing a patient of their condition can be difficult after a gastroscopy, particularly if the patient has been sedated. In my opinion, it was reasonable for Dr C not to inform Mr A of the diagnosis of cancer until an outpatient clinic on 22 March 2000, at which time Mr A's diagnosis was more certain. I am therefore of the opinion that Mr C did not breach the Code in relation to this matter.

Outpatient appointment of 22 March 2000

- *Absence of a support person*

Dr C acknowledged that he did not advise Mr A to bring a support person with him to his appointment on 22 March 2000 when Dr C discussed with Mr A his diagnosis, poor prognosis and further options for treatment. However, I accept Dr C's comments that the CT scan report, which suggested pancreatic cancer, was not seen by him before he saw Mr A at the clinic. Clearly this was suboptimal, particularly since the DHB has advised me that the report would have been available to Dr C no later than 17 March 2000. However, the DHB has changed its policy regarding urgent radiology results so that the radiologist now verbally contacts the referring doctor.

The DHB has also recognised that the absence of a support person at such consultations is not ideal and has advised your family that this issue has been raised with Dr C. In a letter to Ms A dated 10 May 2000, the District Health Board apologised to your family. I am advised that staff do now encourage patients to bring along a family member or friend to get results.

- *Treatment options*

I accept Dr C's comments that he told Mr A, prior to his operation, that the bypass procedure would be palliative and that the cancer was irresectable. I acknowledge that Dr C explained that Mr A would benefit from a bypass operation as he had an obstruction to the stomach outlet and explained the different types of bypasses, with the aid of diagrams, before a joint decision was made to perform an end-to-side bypass. I also acknowledge Dr C's comment that he informed Mr A that these measures might not produce complete relief of his symptoms. I accept my expert advice that it was appropriate to offer Mr A, a bypass operation at this consultation.

- *Shock of hearing news*

I acknowledge the comments made by your family that Mr A would not have been able to make an informed decision about his treatment options after the shock of being informed of his diagnosis. However, I also acknowledge Dr C's comment that if a patient prefers a delay before being informed of possible interventions after being advised of an incurable cancer, he complies with their wishes. On this occasion, Dr C felt that Mr A's problem was urgent. I have seen no evidence that Mr A requested a deferral of the conversation so that a support person could be present, or sought a family meeting. However, it would have been wise for Dr C to do so. The DHB has recognised that a family conference/discussion may have been more appropriate so that family members could ask questions and discuss options for treatment. I consider that both Dr C and Mr A had a responsibility for organising a family meeting. I accept Dr Kyle's advice that Dr C provided Mr A with adequate information and that it was appropriate to discuss the management of the surgical problem at the same time as informing Mr A of his diagnosis.

- *General comments*

Your family stated that following his appointment on 22 March 2000, Mr A thought he had two to four weeks to live. In his response, Dr C commented that he did not inform Mr A of his life expectancy as he believed that the duration could not be predicted with a high degree of accuracy or consistency. I consider it probable that Dr C conveyed to Mr A the seriousness of his condition. However, I am unable to determine, because of the different accounts, whether Dr C was specific about the time Mr A was expected to live.

I accept Dr C's comment that Mr A's wait of one and a half hours for an outpatient appointment was very unusual and that he was unable to explain this delay. I also accept Dr C's comments that patients at the end of his clinic list may be seen later

than their scheduled appointment times because other patients are often seen for longer than their allocated time.

Medications for nausea and pain
Your family stated that Dr C did not provide Mr A with appropriate medication for nausea and pain. As noted above, surgeons often seek advice on the management of pain and nausea in terminally ill patients. It is unfortunate that no satisfactory relationship developed between Mr A and the hospice team. I accept Dr Kyle's advice that this resulted in an undue burden on Dr C to provide a service outside his area of expertise and available time. I note that in an attempt to correct these shortcomings, Dr C advised Mr A's family that they could contact him directly. It appears that Dr C did his best to manage Mr A's pain and nausea.

I accept my expert advice that it was entirely appropriate for Dr C to advise Mr A to discuss a prescription of Celebrex with his general practitioner. Mr A's general practitioner would have been able to explore this suggestion with further medical records, particularly of Mr A's history of drug allergies. I accept the advice of Dr Kyle that this matter should have been dealt with by the hospice staff or Mr A's general practitioner rather than Dr C directly. However, I am of the opinion that Dr C acted wisely in referring Mr A to his general practitioner for consideration of this medication rather than simply prescribing it. In doing so, Dr C did not breach the Code.

In response to my provisional opinion your family said that Dr C told Mr A to "get" but not to "discuss" a prescription of Celebrex with his general practitioner and that he should not have suggested this without checking Mr A's medical notes, which would have indicated that he was allergic to this medication. I accept that this would have been preferable, however Dr C acted wisely in leaving consideration of this matter to Mr A's general practitioner who was aware of his medical history.

Your family also said in response to my provisional opinion that Dr C prescribed Cisapride for Mr A, which made him sick, and that he represcribed it again with the same result. Dr C acknowledged that he prescribed Cisapride twice for Mr A. However he said that on the second occasion the prescription was immediately destroyed as a family member present with Mr A informed him that this medication had previously made him sick. I have made some comments on this issue at the end of my opinion.

Response to telephone request
I acknowledge that Dr C became aware of Mr A's telephone request only three days later. The DHB has recognised that patients can have difficulty in contacting a hospital specialist and there is a problem of messages getting through. I acknowledge the comments made by the DHB that Mr A would have liked to have care from the hospital but that this is not always practical as medical staff may have other commitments. However, I accept the comments made by the DHB that it was wrong to give an impression to Mr A that messages would have got through to Dr C quickly.

I acknowledge that generally, for non-urgent post-operative problems, the patient's general practitioner should be contacted.

Oncology referral
I accept my expert advice that it was entirely inappropriate for Dr C to refer Mr A to an oncologist because Mr A could only be offered palliative treatment.

Insensitive remarks
I acknowledge your family's concern about unsympathetic remarks made by Dr C to Mr A about his life expectancy. Dr C does not recall making these remarks, but if he did they were not intended to be offensive. For this, Dr C unreservedly apologises. In my opinion, no further action is warranted.

Vicarious liability

I have decided that Dr C was not in breach of the Code. It therefore follows that his employer, the District Health Board as the successor to the Public Hospital, is not vicariously liable for his actions.

Other Comments

Responses
Dr C did not respond to my provisional decision. The District Health Board advised that it was happy with my provisional opinion.

Notwithstanding my decision, I wish to make some further comments about the practice of the public hospital and Dr C.

Family involvement
In his response, Dr C commented that he was not aware that your family wanted to discuss Mr A's condition with him. Dr C felt that he had conveyed the information required to Mr A. Dr C noted that a patient's consent to release information to others is important and that if family members want more information it is easier if they attend an appointment with the patient. I acknowledge Dr C's statement that it was Mr A's prerogative to convey information to his family. In my opinion, it was reasonable that Dr C presumed that Mr A was competent to make an informed choice and give informed consent. Therefore, it was not appropriate for Mr C to discuss Mr A's condition with his family unless Mr A wanted him to do so. I note that it would have been appropriate for Dr C to inform Mrs A of Mr A's condition given that she would later become his primary care giver. However, at the time when Mr A was informed of his diagnosis, Dr C reasonably assumed that the hospice would provide the appropriate care. The DHB has noted this issue and advised me that it will ensure the matter of family support is discussed by the consultant if it is not raised by the patient. No policy was not in place at the time and I am satisfied that Dr C acted reasonably in the circumstances.

Hospice/palliative care
In my opinion, in the absence of adequate management of Mr A's symptoms, it would have been prudent for Dr C or other staff members at the public hospital to revisit the option of the involvement of the palliative care team. The hospice team may have provided further advice as to the management of symptoms while Mr A was admitted to hospital and also provided support while Mr A was at home.

Medication
Dr C prescribed Cisapride to Mr A twice when he had suffered side affects from this medication on the first occasion. It was fortuitous that a family member who was present told Dr C this and the second prescription was destroyed. I will emphasise to Dr C the importance of carefully checking a patient's medical history before prescribing medication to ensure the chances of any adverse reactions are reduced as far as possible.

Overall standard of care
I acknowledge the comment in your response that you feel Dr C repeatedly failed to provide services of the appropriate standard to Mr A and that the number of unsatisfactory incidents was totally unacceptable and unprofessional. I will send Dr C a copy of your letter of 19 February 2003 and ask him to reflect on your comments.

Actions

- A copy of my final opinion will be sent to the Medical Council of New Zealand and a second copy, with identifying features removed, to the Royal Australasian College of Surgeons for educational purposes.

Thank you for bringing your concerns to my attention.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

Enc

Ref: 01/00599