Delay in referral of patient with symptoms suspicious of cauda equina syndrome to specialist services (10HDC00454, 25 June 2012)

General practitioner ~ Medical centre ~ Orthopaedic surgeon ~ Public hospital ~ District health board ~ Emergency department ~ Referral to specialist ~ Cauda Equina syndrome ~ Rights 4(4), 4(5)

A 29-year-old woman complained about the care provided by her general practitioner (GP) when she presented with right-sided sciatic pain and tingling in her right foot for four days. The GP considered that the woman was suffering from a disc prolapse and consulted an orthopaedic surgeon at the public hospital, who agreed with this diagnosis and approved of the GP ordering a CT scan. The GP referred the woman for a CT scan and to the orthopaedic clinic, and prescribed pain relief and anti-inflammatory medication.

The next day (a Friday) the woman returned to the GP because her pain was ongoing and she had developed urinary incontinence. The GP considered the urinary incontinence to be a "red flag". The GP tried unsuccessfully to contact the on-call orthopaedic surgeon, left a telephone message, and faxed a referral for the woman to the on-call orthopaedic surgeon's private clinic. The GP contacted the hospital radiologist to bring the woman's CT scan appointment forward, and instructed the woman to go the hospital emergency department [ED] over the weekend if she did not hear from the on-call orthopaedic surgeon or if her symptoms worsened.

Five hours later, the on-call orthopaedic surgeon picked up the GP's message, which did not include the woman's contact details. The surgeon went to the ED and the wards to look for a patient with the symptoms the GP described. No patient of that description presented to the ED over the weekend.

On Monday, the woman had a CT scan. Meanwhile, the GP's referral arrived in the mail at the on-call orthopaedic surgeon's clinic. Enquiries were made and the woman was contacted and asked to present to the clinic. The orthopaedic surgeon operated on the woman later that day to decompress the L5/S1 spinal disc. The woman has a permanent disability as a consequence of her disc prolapse.

It was held that the GP had a duty to ensure that the woman received a specialist review when she re-presented on the Friday afternoon. The GP did not fulfil this duty, did not follow up his telephone message and fax to the specialist, and did not impress upon the woman the need for a timely review. By not ensuring that the woman was reviewed by a specialist in a timely manner, the GP failed to minimise potential harm to her and breached Right 4(4) of the Code. The GP also failed to ensure co-operation among providers to ensure quality and continuity of services and breached Right 4(5) of the Code.

The medical centre was not vicariously or directly liable for the GP's breaches of the Code.

The on-call orthopaedic surgeon acknowledged that he had been advised about a patient with a spinal problem who had developed urinary problems. Although he looked for the patient, he should have made more attempts to track her down. This

failure was an important link in the chain of events that led to the woman not receiving the timely specialist care that she needed.

At the time of these events, the DHB did not have a written protocol for primary care referrals to its hospital ED, and acknowledged that there was no consistent approach from senior medical staff working in specialties with respect to the processing of acute referrals from GPs. Confusion about procedures for GPs to refer patients to hospital specialist services has the potential to affect patient care. Primary care centres and district health boards need to work together to develop clear, unambiguous systems for referring patients between primary and secondary services in their respective areas. Both the medical centre and DHB made changes to improve their systems in this regard.