Waitemata District Health Board

A Report by the

Health and Disability Commissioner

(Case 10HDC00703)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Names have been removed (except Waitemata DHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Executive summary

1. Mrs A had a mastectomy for invasive breast cancer in December 2002 and had been advised that she had an 80 percent risk of the cancer recurring within the next five years. She was an outpatient at the Oncology Clinic at the public hospital. Mrs A also had a history of chronic regional pain syndrome (CRPS) of the knees.

2. On 30 October 2007, Mrs A experienced a sudden onset of back pain during a hydrotherapy session for her CRPS and required immediate admission to hospital. She was assessed at the Emergency Care Centre and an x-ray was taken of her lumbar spine to exclude cancer as a possible cause for her pain. The x-ray showed "no bony lesions" and her spine was of normal alignment. As Mrs A's condition did not improve, she was referred to the General Medical Team the following day.

3. The General Medical Team assessed Mrs A, taking into account her CRPS, breast cancer history and normal x-ray. It was determined that her condition was due to "muscle spasm" and therefore it was requested that Mrs A be reviewed by the Orthopaedic Team.

4. Upon review, the orthopaedic registrar considered that Mrs A had mechanical back pain and advised analgesia and early mobilisation.

5. Mrs A advised HDC that during her admission, she enquired about an MRI scan to a senior doctor but he rudely denied her request, saying that it was not necessary.

6. She was discharged on 13 November 2007, and sought ongoing treatment from her GP, Dr B.

7. In December 2007, Mrs A was seen at the Outpatient Breast Clinic by breast surgeon Dr C and, subsequently, a locum oncologist at the Outpatient Oncology Clinic. Both doctors noted that Mrs A was doing well but made no reference in the record of Mrs A's recent hospital admission or that she was experiencing severe back pain.

8. On 2 May 2008, Dr B referred Mrs A for a bone scan as her back pain had failed to resolve. The scan showed areas highly suspicious for metastatic bone disease, which was later confirmed by an MRI.

9. On 15 August 2008, the family made a complaint to Waitemata DHB about its standard of care, in particular, not referring Mrs A for an MRI during her October-November 2007 admission. On 16 September, the Medical Service Unit Manager responded briefly to the family's concerns, advising that a referral for MRI and to the Oncology Team was not clinically warranted at the relevant time.

10. There was a subsequent meeting between Mr and Mrs A and the Medical Service Unit Manager to further discuss the family's concerns, but the meeting was not successful in reassuring Mr and Mrs A that such a situation would not recur. Waitemata DHB acknowledged that it did not adequately investigate Mr and Mrs A's complaint.

11. Mrs A died in 2011.

Decision

Waitemata District Health Board

12. There were failures on the part of the General Medical Team in ensuring that Mrs A's condition was adequately investigated. In particular, the General Medical Team failed to undertake an MRI or a bone scan in light of Mrs A's cancer history and poor response to analgesia. Furthermore, the General Medical Team did not directly communicate with the Oncology Clinic about Mrs A's admission, despite relying on the Oncology Clinic to consider whether there was cancer-related cause for her pain.

13. The failures of the General Medical Team were service failures and are directly attributable to Waitemata District Health Board (Waitemata DHB) as the service operator. Accordingly, I find Waitemata DHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to adequately investigate Mrs A's back pain, and Right 4(5) for the General Medical Team's failure to communicate adequately with the Oncology Clinic.

Complaint and investigation

14. On 14 September 2009, the Commissioner received a complaint from Mr A about the services Waitemata District Health Board provided to his wife Mrs A.

15. The following issues were identified for investigation:

- *The appropriateness of the care Waitemata District Health Board provided to Mrs A between 30 October 2007 and 13 June 2008.*
- *The adequacy of Waitemata District Health Board's responses to the complaint made on behalf of Mrs A.*

16. An investigation was commenced on 24 August 2010.

17. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr A	Mrs A's husband/complainant
Waitemata DHB	Provider
Dr B	General practitioner

Information was reviewed from:

Mrs A
Mr A
Waitemata DHB
Dr B

Also mentioned in this report:

Dr C	Breast surgeon
Dr D	Emergency medicine specialist
Dr E	Consultant physician and gastroenterologist
Dr F	Orthopaedic registrar
Dr G	Registrar
Dr H	Oncologist
Dr I	Oncologist
Dr J	Orthopaedic surgeon
Ms K	Mrs A's cousin
Ms L	Unit Manager

18. Independent expert advice was obtained from independent consultant physician, Professor Carl Burgess. A copy of Professor Burgess' report is attached as **Appendix A.**

Information gathered during investigation

Background

19. In 2002, Mrs A was diagnosed with breast cancer and had a right partial mastectomy. In 2003, she was advised by her oncologist that there was an 80 percent chance that the cancer would recur within the next five years. Mrs A underwent radiotherapy, chemotherapy and was prescribed Tamoxifen[1] to help reduce the risk of cancer recurrence. Between 2004 and 2008, Mrs A received outpatient care at the Medical Oncology Clinic at the public hospital.

20. In April 2005, Mrs A was diagnosed with Chronic Regional Pain Syndrome (CRPS) of the knees as a result of a fall in 1999.

21. In June 2007, Mrs A suffered a further injury to both knees. She sought treatment from an orthopaedic surgeon and was subsequently referred to the Physiotherapy Department at the hospital.

22. Mrs A's GP during the relevant time was Dr B.

[1] Tamoxifen is an anti-estrogen medication used to treat breast cancer. Tamoxifen can be used as an adjuvant therapy (treatment given after the primary treatment), to help prevent the original breast cancer from returning and also helps prevent the development of new cancers in the other breast. As a treatment for metastatic breast cancer, the drug slows or stops the growth of cancer cells that are present in the body. Mrs A was advised to remain on Tamoxifen for the next four years as part of her post-operative cancer treatment.

Hospital admission: 30 October – 13 November 2007

23. On 30 October 2007, during a hydrotherapy session for her CRPS, Mrs A experienced a sudden onset of severe left lower back pain without suffering any trauma. She was immediately admitted to the Emergency Care Centre (ECC) at the hospital.

24. Mrs A was assessed at 11.50am by emergency medicine specialist, Dr D.[2] Dr D noted Mrs A's history of breast cancer and recorded in the clinical notes "Imp. [Impression] Unlikely bony lesion but needs to be excluded given previous [cancer] breast". An x-ray of Mrs A's lumbar spine was taken at 12:34pm. The x-ray revealed:

> "Findings: The lumbar spine is of normal alignment. The vertebra height and disc spaces are maintained. No suspicious bony lesions."

25. Mrs A was given pain relief and diazepam for her back pain and was kept in ECC overnight. As there was only minimal improvement in her condition, she was referred to the General Medical Team for further assessment on 31 October 2007.

Referral to the General Medical Team

26. On 1 November, Mrs A was seen by consultant physician and gastroenterologist, Dr E. Taking into account Mrs A's recent lumbar spine x-ray and history of CRPS, Dr E's "impression" was that her condition was due to "muscle spasm" and requested a review by the Orthopaedic Team.

27. Mrs A was reviewed by orthopaedic registrar, Dr F[3] later that day. He diagnosed her with musculoskeletal pain lumbar spine syndrome of acute disc prolapse and advised analgesia with early mobilisation.

28. During Mrs A's admission, she received analgesics, diazepam and Sevredol.[4] The medication appeared to have little effect in relieving Mrs A of her severe back pain. Entries made in the clinical notes on 2 and 3 November record that Mrs A was unable to mobilise without assistance and only felt comfortable when lying in bed. The notes indicate that it was not until 4 November that Mrs A felt her back pain was becoming, to some extent, manageable.

Referral to the Pain Team

29. On 7 November, Mrs A was referred to the Pain Team. The referral letter outlined the ongoing nature of Mrs A's back pain and the difficulty the General Medical Team was having in managing her pain. The referral letter states:

> "This lady presented [with] [left] back & hip pain 10/10 sharp. X-rays [no active disease]. Usually only on Panadol, ibuprofen for the CRPS.

[2] Dr D now resides overseas. The DHB contacted Dr D for comment. He reviewed the records he made of his assessment of Mrs A on 30 October 2007, but was unable to recall any details.
[3] Dr F is no longer employed by Waitemata DHB. Waitemata DHB was unable to locate Dr F during the course of HDC's investigation.
[4] An opioid pain relief.

> On Panadol, ibuprofen, Diazepam, M-Elson 30mg BD regularly & prn sevredol now. Pain not really improving. Can you please advise us on further medications we can use. She is not under any Pain Clinic. Her CRPS is managed by GP & Physio. Thank you."

30. An x-ray of Mrs A's left hip and pelvis was taken later that day, revealing no fractures.

31. On 9 November, Dr B telephoned the Pain Team requesting to speak to the registrar, Dr G, to discuss Mrs A's management upon discharge. The hospital clinical notes record the following message:

> "We were rung by [Mrs A's] GP [Dr B] who would really like to have a chat with you – she wants to know what [Dr G] will be recommending. She really doesn't want patient to go home on opioids even though we have told her it will be a short term thing until pain is under control. Can you please call her at home [phone number]."

32. Dr B's clinical notes record that a house surgeon returned her call later that day and the following was discussed:

> "ph call from h/surgeon as [Mrs A] will poss go home tomorrow. Seen by pain team TODAY for the FIRST time & they are trying [gabapentin] but ess [essentially] the plan is to dx her on Meslon 30mg bd & diazepam 5 mg bd & her usual paracetamol & ibuprofen & PRN sevredol this is despite my talking with the Reg last week re her pre existing pain problem & inadvisable to dx her on narcotics. They do think it is mechanical back & some L greater trochanter bursitis & will improve?? There was no fall or trip in the pool was just walking along & sudden onset of severe pain but they have not done a bone scan etc ..."

33. In Dr B's written statement to HDC, she states "I do not believe I asked for an MRI nor a bone scan during that phone call". However, she was conscious of Mrs A's cancer history and thought that the General Medical Team would be considering this history in their assessment. She explained that the main reason for her call was that another of her patients had been treated with morphine by the hospital which, in her opinion, was not appropriate, and she did not want the same thing to happen to Mrs A.

34. On 10 November, Mrs A was examined by Dr G. He noted Mrs A's history of breast cancer and that she was being treated with Tamoxifen. Dr G documented a pain relief plan, which included commencing a trial of Gabapentin[5] for 24 hours.

35. Mrs A advised HDC that a couple of days prior to discharge, a nurse advised her that there was something else going on that was causing her back pain and that she should request an MRI. Mrs A claimed that she subsequently requested an MRI. Mrs A said that a male doctor, who was accompanied by a younger female doctor, declined her request in a condescending tone and told her that an MRI scan was not necessary. Mrs

[5] Medication to treat neuropathic pain.

A recalled that the senior doctor told the junior doctor, "That is what her doctor has been asking" and then turned to Mrs A and said, "Your doctor has upset my colleague here." Mrs A said that she was told to "go home for another 6 months and wait". Mrs A did not know the name of either doctor or the date of the alleged conversation. There is also no clinical record of the alleged conversation.

36. On 11 November, Mrs A was reviewed again by Dr G. He noted that she had been assessed by the Orthopaedic Team, which concluded that she had musculoskeletal pain, and that her CRP[6], calcium, ALP[7] and lumbar x-rays were normal. Dr G conducted a physical examination and found that Mrs A's symptoms were consistent with musculoskeletal back pain and not CRPS. He discussed his findings with the anaesthetic consultant, who recommended that Mrs A be weaned off the opioid, her gabapentin be stopped, and Mrs A be started on simple analgesia and amitriptyline. Dr G advised HDC that "[Mrs A's] pain was not progressive, there [were] no signs of nerve impingement and [she] was improving to the point [that] she [could be] discharged to the community. This was why there were no specific orders to further investigate her".

37. Dr B stated she received two telephone calls from the Pain Registrar[8] during the weekend of 10 and 11 November about Mrs A's discharge from Hospital. Dr B stated that they talked about the fact that a bone scan had not been performed. She stated that the Registrar advised her that his brief was pain management prior to discharge and that he was not involved in the diagnosis. Dr B advised that as she took these telephone calls when she was at home, she did not document them. There is, however, a reference to the two phone calls in an entry dated 21 November 2007 but no detail as to what was discussed. There is also no hospital record of the telephone calls being made.

38. On 13 November, Mrs A was discharged with a prescription for pain relief and a physiotherapy referral. Her discharge summary was only sent to Dr B and not to the Oncology Clinic, where Mrs A was an outpatient. There is no record of any communication between either the General Medical Team or the Pain Team, and the Oncology Clinic in relation to Mrs A's admission.

Follow-up care

39. In December 2007, Mrs A was seen at the Outpatient Breast Clinic by breast surgeon, Dr C. He noted that she was "doing well from the point of view of her breast cancer" as there was no evidence of recurrence, and discharged her from further follow-up at the Breast Clinic. There is no reference in Dr C's clinical notes of Mrs A's October admission or back pain.

40. On 31 January 2008, Mrs A was seen by oncologist, Dr H at the Outpatient Oncology Clinic.[9] Dr H told HDC that her assessment of Mrs A included an inquiry into Mrs

[6] C reactive protein, a blood test to detect inflammation.
[7] Alkaline phosphatase, a blood test to detect liver disease and bone disorders.
[8] It is not known whether the Pain Registrar was Dr G or another member of the Pain Team.
[9] Dr H was the relieving registrar for Mrs A's oncologist, Dr I.

A's recent health. Dr H does not recall any discussion about Mrs A's October 2007 hospital admission.

41. Mr A advised HDC that Mrs A was receiving treatment after her discharge from an osteopath who had manipulated her back, which temporarily resolved her pain. Mr A believes that as a result, she was not experiencing any pain at the time of her appointments with Drs C and H, which would explain her not mentioning the recent hospital admission.

42. On 2 May 2008, Dr B referred Mrs A for a bone scan, and a referral to a regional pain service was made on 8 May 2008. In both letters, Dr B stated that the referral was to exclude the possibility of cancer as the cause of Mrs A's pain.

43. The bone scan was performed on 26 May revealing Mrs A's spine to be "highly suspicious for secondary bone deposits from known CA breast [breast cancer]".

44. On 30 May, Dr B telephoned orthopaedic surgeon, Dr J, to request his assistance to organise an MRI scan for Mrs A. Dr J advised HDC that Dr B thought that Mrs A may have metastatic cancer breast to the spine and that she was struggling to get an urgent MRI of the spine to exclude or confirm such possibility. Dr J stated that he was happy to comply with Dr B's request, which he regarded as more than reasonable.

45. Mrs A attended her appointment with Dr J on 4 June 2008. Dr J advised HDC that he examined Mrs A during the consultation but did not look at Dr B's referral letter or the bone scan report, which Mrs A had taken to the consultation. Dr J advised HDC that he would not have opened the letter or the bone scan report because of the short timeframe between the verbal referral and appointment. Moreover, he advised that Mrs A's main concern that day was her painful knees and not her back. In any event, he was not prepared to talk about metastatic disease without appropriate imaging and tissue diagnosis.

46. Dr J reported the consultation to Dr B in a letter dictated on 4 June. He advised Dr B that Mrs A's symptoms were "more explainable on the basis of arthritis rather than CRPS" and recommended that Mrs A start a course of glucosamine. Dr J did, however, refer Mrs A for an MRI to examine the lumbosacral region but doubted that an MRI would show anything except arthritis.

47. The MRI was performed on 13 June 2008 and confirmed metastatic bone disease in Mrs A's spine and pelvis. Mrs A died in 2011.

Complaint to Waitemata DHB

48. On 15 August 2008, Mrs A's cousin, Ms K, complained to Waitemata DHB about the standard of the care it provided to Mrs A. Ms K stated that the family was upset that Mrs A was diagnosed with metastatic cancer on 13 June 2008, when she had requested an MRI during her admission.

49. On 16 September, Ms K received a response from Unit Manager, Ms L. Ms L advised Ms K that an MRI scan was not indicated as Mrs A had "no neurological or

radiological abnormality" to support a referral. She also stated that Dr E had discussed the issue with an orthopaedic colleague, who concurred that his decision was correct based on Mrs A's condition at the time.

50. Ms L said that she had discussed with Dr E Mrs A's claim that a senior doctor had rudely denied her request for an MRI, and he was "both baffled and distressed" at the allegation, as it is something that he would never do.

51. Waitemata DHB subsequently advised Mr and Mrs A that another attempt to follow up her concern was made, but the doctor that may have been involved had moved on and was not able to be contacted.

52. Ms K was dissatisfied with Ms L's response and wrote again on 11 October 2008. Ms L reiterated that the General Medical Team did not feel that Mrs A's symptoms warranted an MRI.

53. On 25 May 2010, Mr and Mrs A met with Ms L to discuss Waitemata DHB's investigation. Mr A advised HDC that Ms L stated she was "the wrong person to answer their questions, as the questions were related to the Orthopaedic team" and she was trying to organise a meeting between Mr and Mrs A and that team. Mr A stated that he made a number of suggestions to improve Waitemata DHB's service quality; however, his suggestions were "dismissed without consideration".

54. Mr A said that he also asked why the Oncology Clinic was not asked for their clinical opinion as to diagnosis. He was advised that the belief was that the Oncology Clinic would "look into it" at Mrs A's next appointment and that the records of her admission were accessible to the Oncology Clinic and should have been considered. Mr A stated:

> "This portrays a tunnel vision approach to the diagnosis of my wife's condition, one that once started, no-one wanted to change. Considering that my wife has 2 chronic illnesses, why did no-one, apart from the ED doctor, think to check the spine for cancer. What is more disturbing is the impression that they would do the same again."

Waitemata DHB's response to HDC

55. Waitemata DHB advised HDC that the management of Mrs A's acute onset of back pain in October and November 2007 was made more complex by two underlying chronic disorders: CRPS and breast cancer. The General Medical Team were aware that Mrs A was being followed up by the Outpatient Oncology and the Breast Clinics. The General Medical Team therefore considered it reasonable to focus their attention on Mrs A's acute presenting symptom at that time, which was her back pain.

56. The Clinical Director of Medicine advised HDC that because of the complexity of Mrs A's condition, care was divided and responsibility for the acute event was limited to that admission. He further stated that "the acute team were well aware that this patient was being followed up by both medical oncology and the breast surgeon. It

was therefore not inappropriate for them to expect the issue of metastasis to be considered by others."

57. Waitemata DHB confirmed to HDC that there was no direct communication between the General Medical Team and the Oncology Team about Mrs A's admission or discharge. Waitemata DHB advised that the onus for notifying any other appropriate medical team about a patient's care lies with the admitting team. In Mrs A's case, the admitting General Medical Team did not advise the Oncology Team of Mrs A's admission or discharge as the "General Medical Team did not deem it relevant". The team's impression of her condition was that "she had worsening chronic back and hip pain that was managed by a review of analgesia and increased physiotherapy input both as an inpatient and outpatient".

58. Waitemata DHB noted that, in any event, the Oncology Clinic, as with any other service within the DHB, has access to patient notes and electronic clinical records to ensure that they are informed about a patient's current clinical information and facilitate continuity of care. The Waitemata DHB did state, however, that it would have been good practice in this situation for the General Medical Team to have contacted Mrs A's oncologist, Dr I, to inform him of Mrs A's recent admission and presentation. This would have given Dr I the opportunity to offer advice or make a suggestion for further investigation if he deemed it appropriate.

59. Waitemata DHB advised that it has been unable to clarify the matter of the doctor who Mrs A alleged spoke to her in an unacceptable manner when she requested an MRI scan. The DHB advised HDC that the doctor who made the unprofessional statement cannot be identified by the hospital records but that Dr E advised he was not responsible for the remarks and the DHB note it would be "most out of character for him" to make such remarks.

60. In relation to the decision not to order an MRI, Waitemata DHB stated that when a lumbar radiograph does not show an abnormality, but there is a high clinical suspicion of pathology, the specialist usually refers the patient for other tests such as a bone scan or MRI. If the clinician has a sufficiently high clinical suspicion of a metastasis despite a normal radiograph, they do not require the radiologist to suggest additional tests for a referral to be made. Waitemata DHB could not get in contact with Dr F but stated, "We can only surmise that [Dr F] based his rationale [for not ordering a MRI scan] on the combined history, physical examination findings, normal lumbar X-ray and inflammatory markers he had at hand at the time".

61. Waitemata DHB stated that in view of Mrs A's eventual diagnosis of secondary spinal metastases and the subsequent concerns raised by Mr and Mrs A, there has been learning by the clinical teams involved in Mrs A's care. The DHB stated:

> "It has certainly made clinicians more aware of expanding their focus when treating back pain/spinal patients. It has also highlighted the importance of communication between services and externally to our primary care colleagues to ensure continuity of patient care."

Changes made by Waitemata DHB

62. Waitemata DHB advised that it takes complaints seriously and endeavours to investigate concerns fully. Waitemata DHB acknowledged to HDC that the complaint was not investigated adequately. It advised that as part of the quality restructure to ensure consistency of process across the DHB, a Sentinel Events Lead and Complaints Co-ordinator were appointed to support and co-ordinate service managers with their complaint investigations in April 2010. Waitemata DHB reports that this has resulted in a more efficient patient-focused process and that outcomes and corrective actions are now completed in a timely manner.

63. In relation to communication, Waitemata DHB advised that a review of its communication processes between primary, secondary and tertiary health care was undertaken with a view to ensuring a robust and consistent communication process.

Response to the provisional opinion

64. Waitemata DHB responded that it accepts responsibility for the failings identified in my provisional report and that it has no comments to make in relation to those matters.

65. Waitemata DHB has made substantive comments in relation to my proposed recommendations. It advised that a review of communication processes between primary, secondary and tertiary health services was undertaken as part of the Northern Region Health Plan (NRHP), which involved Waitemata, Auckland, Counties Manukau and Northland DHBs. As part of the NRHP planning process, a Northern Regional Information Strategy for 2010-2020 and a Northern Regional Information Systems Implementation Plan were developed, setting the direction for information management, systems and services across the region. The "Five information systems priorities" identified in the 2011/2012 NRHP are i) a single patient administrative system; (ii) a single clinical workstation; (iii) a regional clinical data repository; (iv) a population health data repository; and (v) a regional information service delivery and infrastructure strategy.

66. Waitemata DHB advised that the implementation of the first systems priority will allow the four northern region DHBs to share a single workstation system. Implementation of the second priority will allow medical documents to be stored in a central repository that can be accessed by all users, including GPs. Waitemata DHB also advised that there are a number of regional projects underway to enhance communication between all service levels, including electronic referrals, discharges, rostering, and laboratory ordering.

67. Waitemata DHB advised that a revised complaints policy was implemented in March 2011. The focus of the revised policy is on clinician engagement, patient-centred investigation, and resolution completed in a timely manner. A weekly report is sent to

all senior managers and clinicians identifying all open complaints, their current progress, and tracks a 14-day response target.

68. Waitemata DHB advised that Mrs A's case was used to reinforce to clinicians the standard recommendations for managing back pain, indications for further investigation and MRI scanning, and the need for clear communication and coordination between services. Waitemata DHB also has a teaching programme for its orthopaedic registrars.

Breach Opinion — Waitemata District Health Board

Adequacy of clinical investigation and communication with the Oncology Clinic

69. When Mrs A was first admitted to the ECC, Dr D noted Mrs A's history of breast cancer and sought an x-ray of her lumbar spine. The x-ray was clear for bony lesions, which led to an assumption that Mrs A's back pain was unrelated to her cancer history.

70. Mrs A was then referred to the General Medical Team who, despite Mrs A's pain remaining unresolved with analgesia, and following a review by an orthopaedic registrar, also chose not to undertake an MRI scan or bone scan of her spine. Rather, the General Medical Team concluded that the cause of Mrs A's pain was musculoskeletal and referred her to the Pain Team for assistance with pain management.

71. My expert advisor, general physician, Professor Carl Burgess, has criticised the use of x-ray to rule out metastatic bone disease in a patient such as Mrs A. He stated:

> "I would have thought that with the history of carcinoma of the breast and the fact that the pain occurred spontaneously with no fall or severe trauma and there was a poor response to [pain medication] should have necessitated further intervention. X-rays of the spine are inadequate in diagnosing metastatic bone disease. The best investigation would have been an MRI scan but a bone scan would have alerted the clinicians to the fact that there was an abnormality over the area of pain."

72. The referral to the Pain Team from the General Medical Team states that Mrs A had CRPS, details her usual medications for that condition, and notes that the CPRS is managed by her GP and physio rather than any pain clinic. Mrs A's history of breast cancer is not mentioned, nor is the fact that she was also taking Tamoxifen regularly at that time to help prevent recurrence of that cancer. The focus of the referral was clearly on Mrs A's CRPS.

73. However, as noted by Professor Burgess, at the time of Mrs A's admission she was only taking Panadol and Nurofen for her CRPS, which should have alerted the teams that her CRPS, although painful, was not a significant problem.

74. I agree with Professor Burgess that, while the steps taken to manage Mrs A's pain were adequate, those taken to diagnose the cause of that pain were not. Given Mrs A's history and her presentation on admission, an MRI scan, or at least a bone scan, should have been done to exclude the possibility of metastatic bone disease. Questions about the cause of Mrs A's pain should have continued to have been asked throughout her admission.

75. In responding to the complaint, Waitemata DHB's Clinical Director of Medicine explained that because of the complexity of Mrs A's clinical presentation, and that the General Medical Team was aware that she was being followed up by the Oncology and Breast Clinics, it was reasonable for the General Medical Team to focus their investigation on Mrs A's back pain. The Clinical Director of Medicine claims that it was "not inappropriate for the [General Medical Team] to expect the issue of metastasis to be considered by others" because Mrs A was being followed up by the Oncology Clinic, and the clinic had access to the electronic records of Mrs A's admission.

76. I accept that Mrs A's condition was made more complex by her history of CRPS and breast cancer. However, I do not accept that it was reasonable to assume that the possibility of cancer would be picked up by the Oncology Clinic without directly informing that clinic about Mrs A's admission. In my view, if the General Medical Team was aware that Mrs A was an Oncology Clinic outpatient, and thought that cancer was a possible diagnosis, then it would have been appropriate for the General Medical Team to consult with the Oncology Clinic during Mrs A's admission. As noted by Professor Burgess, such communication may have prompted further investigation as to the cause of Mrs A's pain. At the very least, given the particular circumstances, on discharge the General Medical Team should have taken reasonable steps to alert the Oncology Clinic to the existence of the discharge summary in the electronic record.

77. In my view, the General Medical Team failed to adequately investigate Mrs A's condition and thus did not provide services to her with reasonable care and skill. In addition, by failing to appropriately communicate with the Oncology Clinic, the General Medical Team did not ensure continuity of care for Mrs A.

78. I note that the Oncology Clinic does not appear to have been aware of Mrs A's admission or the back pain she had been experiencing. Notwithstanding the lack of direct advice from the General Medical Team, the Oncology Clinic had other avenues for obtaining information about Mrs A's admission: from Mrs A's electronic medical record to which they had access; or from Mrs A herself. I am concerned that the relevant information does not appear to have been successfully elicited from either source.

District health board responsibility

79. District health boards are responsible for the operation of clinical services within hospitals and can be held responsible for any service-level failures.

80. As noted above, in this case, there were failures on the part of the General Medical Team in ensuring that Mrs A's condition was adequately investigated and in communicating with the Oncology Clinic. The General Medical Team failed to undertake an MRI or a bone scan in light of Mrs A's cancer history and poor response to analgesia. Furthermore, the team did not directly communicate with the Oncology Clinic, despite relying on the Oncology Clinic to consider the issue of cancer.

81. In my view, this is a case of different services within a district health board each considering a patient from their own specialist viewpoint, without having regard to the bigger picture of the patient's presentation and seeking to co-operate with one another to provide continuity of care to the patient. It is a case where clinicians should have continued to ask the pertinent questions while the patient was under their care. Instead, what resulted was a pattern of suboptimal care, characterised by missed opportunities to diagnose Mrs A's metastatic bone disease.

82. The failures of the General Medical Team were service failures and are directly attributable to Waitemata DHB as the service operator. Accordingly, I find Waitemata DHB breached Right 4(1) of the Code for failing to adequately investigate Mrs A's back pain, and Right 4(5) for the General Medical Team's failure to communicate adequately with the Oncology Clinic.

Recommendations

83. I have made the following recommendations in relation to Waitemata DHB:

1. Review its processes to ensure all relevant hospital services involved with a patient are alerted when a patient is admitted and discharged;
2. Provide evidence of its review of the communication processes between primary, secondary and tertiary health care services;
3. Review its complaint investigation process, and provide evidence of any changes made to improved that process;
4. Provide evidence of the training given to the orthopaedic department regarding the management of spinal patients; and
5. Apologise to the family for the poor care provided to Mrs A during her October-November 2007 hospital admission.

84. Waitemata DHB advised that recommendations (2), (3) and (4) are completed as outlined in the "Response to the provisional opinion" section of this report.

85. Waitemata DHB has provided Mr A with a written apology in accordance with recommendation (5).

86. I recommend that Waitemata DHB conduct a review in accordance with recommendation (1) and provide a report to HDC by **30 November 2012**.

87. I also recommend that Waitemata DHB advise me of the progress made in relation to the implementation of the "Five information systems priorities" by **30 November 2012.**

Follow-up actions

- A copy of the final report with details identifying the parties removed, except the experts who advised on this case and Waitemata DHB, will be sent to DHBSS (DHB Shared Services) and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Waitemata DHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A - Independent advice to the Commissioner – Physician Carl Burgess

The following expert advice was obtained from Professor Carl Burgess:

"I have been requested to provide expert advice in regard to the care and treatment provided by Waitemata District Health Board to [Mrs A] in 2007-2008. Was it an adequate and appropriate standard? In particular I have been requested to address the following points:-

1. Was the General Medicine team's management of [Mrs A's] back pain during her admission in October 2007 appropriate?

2. Were there any other interventions that should have been considered?

3. Was the discharge and follow-up plan appropriate?

4. Should the outpatient clinic clinicians, who reviewed [Mrs A] in December 2007 and January 2008, have been aware of her admission in October 2007 for back pain, and considered further investigation?

5. Please comment on the overall effectiveness of communication between the teams involved in [Mrs A's] care.

6. Are there any systemic or provisional service issues of note affecting [Mrs A's] care that you consider warrant comment?

I have received the following documents:-

1. Complaint to the Commissioner from [Mr. and Mrs A], received 14 September 2009, marked with an "A".

2. Response from GP, [Dr B], received 15 September 2010, marked with a "B".

3. Responses from Waitemata DHB, dated 20 November 2009 which included a copy of [Mrs A's] clinical records and 19 October 2010 marked with a "C".

4. Response from Waitemata DHB, dated 8 December 2010, marked with a "D".

Before providing answers to the above questions it would be advisable to review [Mrs A's] history.

[Mrs A] was admitted to Waitemata DHB on 30 October 2007 with a history of sudden onset of severe back pain whilst attempting to exit a physiotherapy pool where she was having hydrotherapy for a painful left knee following a fall about 2 months

previously. In her past medical history she had surgery to her right knee in 1999 but had developed ongoing pain in that leg that had been diagnosed as Chronic Regional Pain Syndrome (CRPS). In 2002 she had been diagnosed with a grade 3 infiltrating ductal carcinoma of the right breast and had undergone a mastectomy followed by adjuvant chemotherapy and radiotherapy. She was also placed on tamoxifen. In 2005 she had had an appendectomy and subtotal hysterectomy. She was taken from the physiotherapy pool to the Accident and Emergency Department of [the public] Hospital where it was noted that she was severely limited by pain that was exacerbated on movement. Conservative treatment with analgesics, diazepam for muscle spasm and physiotherapy was ordered. An x-ray of the lumber spine was reported as within normal limits. However there was only minimal improvement in her condition. [Mrs A] was admitted to the General Medicine service on 31 October 2007. A referral was made to the orthopaedic service and [Mrs A] was reviewed by the orthopaedic registrar who noted tenderness over the lumbar spine from L2 to L5. He could not demonstrate any neurological signs but did note her prior history of chronic pain. The examiner felt that the most likely diagnosis was pain due to musculoskeletal disorder and suggested further analgesia and mobilization. [Mrs A's] analgesia was increased and she was trialled with both short and long acting morphine preparations. Her back pain was helped, but she still had trouble mobilizing. There was very gradual improvement and prior to discharge she was seen by the hospital pain team who recommended a trial of gabapentin, but this failed to help her. She was discharged from the hospital on 13 November 2007 taking the following medication, paracetamol, ibuprofen, amitriptyline, short and long acting morphine and laxatives. She was to be followed up by the general practitioner. The general practitioner, [Dr B] had been in contact with the medical team and also with the pain team in regard to them using morphine. She (the GP) requested the lowest dose of morphine possible. [Mrs A] was also followed with regular appointments at the oncology clinic. She was seen in the surgical oncology clinic in December 2007 where it was noted that her breast cancer seemed to be under control but no note is mentioned of the back pain or the admission to hospital, she was discharged from this clinic. Similarly her visit to the oncology clinic in January 2008 also noted good progression in regard to her breast cancer but no mention was made of the admission to the medical ward in October/November 2007. Meanwhile she was followed by her general practitioner at frequent intervals and it is clear from the general practitioners notes that [Mrs A] was still troubled with back pain and required the use of morphine on a regular basis. After the GP spoke with a member of the pain clinic at the hospital, a bone scan was ordered that showed an area at L1 that was highly suspicious for secondary bone cancer from the known cancer of the breast. It also reported that this might be associated with a vertebral crush fracture; there were also faint changes noted at L4. [Dr B] organised an urgent outpatient appointment for [Mrs A] with the orthopaedic surgeon and asked that an MRI scan be done. The MRI scan was performed on 13 June and this confirmed metastatic bone disease in the spine and pelvis. These are the circumstances of this complaint.

My answers to the questions posed are as follows:

In regard to the care and treatment by Waitemata DHB to [Mrs A] in 2007-2008, although the treatment of her pain was adequate, the attempt to make a diagnosis was inadequate. It was known that [Mrs A] a high grade cancer of the breast and she had developed severe spontaneous pain that did not respond adequately to standard analgesia. Under such conditions one might have expected that the clinicians would have attempted to find a cause for the underlying pain. Much has been made in the notes of [Mrs A's] previous history of chronic regional pain syndrome affecting her leg. It may be that practitioners felt that this presentation was part of a similar disorder. However, according to the clinical record the only medication that [Mrs A] was taking on admission was tamoxifen which is an anti-estrogenic medicine and is not used for pain. As far as I can ascertain she was on no regular analgesics prior to this admission. This should have alerted the clinicians to the fact that her pain in her leg, although a problem to [Mrs A], was not severe. Generally the standard of care was fair in that she had access to physiotherapy and access to analgesia. However her discharge does not seem to have proceeded well. During her stay in the hospital, her general practitioner, [Dr B], contacted the medical team and the pain teams in regard to [Mrs A] discharge medicines and care. There was no attempt by the General Medicine department to arrange to see her in the clinic or make sure that the oncology team was aware of the admission and would arrange an early appointment to assess [Mrs A's] progress. They (the Medical team) may have thought that the Oncology would be aware of [Mrs A's] admission, because the discharge summary was on the clinical record on line, but I'm unsure whether this was available at Waitemata DHB at that time. Lastly, [Mrs A] was a complex patient with requirement for ongoing potent analgesia, perhaps she should have been seen in the outpatient pain clinic, particularly as the GP had contacted the team with concerns prior to discharge.

In response to the particular questions, they are as follows.

1. Was the general medicine team's management of [Mrs A's] back pain during her admission in October 2007 appropriate?
The medical team's management was based on the orthopaedic registrar's suggestion and then more latterly during her stay in hospital to the pain management team. It was plain that [Mrs A] was not responding adequately to the doses of opiates adequately to mobilize her sufficiently for her to leave the hospital. This is not unusual in that in past years patients such as [Mrs A] would probably have been admitted to an orthopaedic ward initially with perhaps earlier oncology input; that might have resulted in earlier investigation. Of more recent times, most orthopaedic services in New Zealand have abdicated from taking such patients as they prefer patients where an operative course will be followed, so many of these patients are now admitted under general medicine. Perhaps there is inadequate training for general medicine teams in the assessment and management of pain. This is particularly so when the pain does not come under control rapidly. I would have thought that it would have been important in this particular case for the medical team to have asked the orthopaedic team to revisit the patient. The pain team did not seek a cause for [Mrs A's] pain but rather offered a different kind of analgesic for her. This was gabapentin in the belief that perhaps the pain was of the neuropathic variety. Therefore the use of the pain team may be seen to be appropriate but I believe their function is not only the

treatment of pain, but also to identify the cause if possible as this may alter the choice of the therapeutic agent.

2. Were there any other interventions that should have been considered?
Although it is easy looking back to say a bone scan or an MRI scan should have been performed, I would have thought that with the history of carcinoma of the breast and the fact that the pain occurred spontaneously with no fall or severe trauma and there was a poor response to treatment should have necessitated further intervention. X-rays of the spine are inadequate in diagnosing metastatic bone disease. The best investigation would have been an MRI scan but a bone scan would have alerted the clinicians to the fact that there was an abnormality over the area of pain.

3. Was the discharge and follow-up plan appropriate?
No. It is not clear from the discharge what the follow-up plan was (see above). I presume that the intention was that the general practitioner would do the follow-up. At the time, [Mrs A] has been requiring opiates on a regular basis. The general practitioner has voiced concerns in regard to this matter but it seems was left to look after the patient. The medical team would have known that [Mrs A] would have been followed in oncology outpatients and I would have thought that it would have been apposite for them to have made sure that a discharge summary was sent to that clinic and to the clinician involved with her care. Similarly, as I remarked on earlier, perhaps a clinic appointment with the pain specialists ought to have been arranged.

4. Should the Outpatient Clinic clinicians, who reviewed [Mrs A] in December 2007 and January 2008, have been aware of her admission in October 2007 for back pain, and considered further investigation?
I am surprised that in neither of the letters was there any mention of [Mrs A's] admission to the hospital nor did there seem to be any enquiry in to whether [Mrs A] was taking any additional medication or whether she had any other symptoms. It seems that the individual clinicians were concentrating on the disease process that they were treating [Mrs A] for. As I mentioned earlier, I am unsure of what kind of clinical record was available to other clinicians at [the public] Hospital at the time that [Mrs A] had her admission. Even if the discharge summary was on the clinical record, an individual clinician would have to go and look for it. The answer to the question is they should have been made aware of her admission and I think in such circumstances the Oncologist would certainly have considered further investigation.

5. Please comment on the overall effectiveness of communication between the teams involved in [Mrs A] care.
In regard to the communication between the General Medical team and the Orthopaedic team whilst [Mrs A] was in hospital there seems to have been only one visit by the Orthopaedic department. The orthopaedic registrar made it clear that he did not feel that there was any role for his specialty in [Mrs A] care and therefore did not envisage returning to see her. In regard to the pain management team they did not revisit the patient to see whether she had responded to gabapentin. In fact she hadn't and the gabapentin was stopped. There seems to have been no communication between the general physicians and the Oncology department. I would have thought

that had there been communication, then this patient may well have been taken over by the oncologists and further investigations performed.

6. Are there any systemic or provisional service issues of note affecting [Mrs A's] care that you consider warrant comment?
I believe that the provision of service was adequate but there was a failure of communication certainly between the Medical team and the Oncology team. I would think that because of the difficulty that many general physicians have in managing patients with pain syndromes, their simple acceptance of the orthopaedic registrar's view and because the plain x-ray of the spine was normal they felt that the diagnosis of musculoskeletal cause of pain was acceptable was where the problem arose. There obviously needs to be some improvement in communication when the patient is sent out of hospital to another team who are going to look after this patient in the future.

In regard to the appropriate standard of care I would have thought that this did not meet standards that would be acceptable and I would put this down as mild disapproval.

One could argue that an earlier diagnosis of [Mrs A's] care would probably not have altered prognosis, this is probably true, however [Mrs A] would have been seen earlier by the oncology team and she would have probably have been given radiotherapy earlier which may very well have relieved her pain and improved her quality of life."

Additional advice
"I have been requested to provide a further report in regard to the care and treatment provided by Waitemata District health Board to [Mrs A] in 2007-2008. In particular, I have been asked to comment on the following:-

- Whether the steps the general medical team took during [Mrs A's] October 2007 admission to arrive at a diagnosis were adequate.
- If not, what was the degree of the departure from the standard?
- Whether the general medical team's failure to communicate to the oncology team about [Mrs A's] October/November 2007 admission is a departure from the expected standard.
- If so, what was the degree of that departure?

I have provided with my original report dated 14 February 2011; additional information provided by Waitemata DHB dated 25 May 2011; a telephone conversation with [Dr B], dated 26 May 2011; and further additional information provided by Waitemata DHB on 22 June 2011.

My responses are as follows:-

Whether the steps the general medical team took during [Mrs A's] October 2007 admission to arrive at a diagnosis were adequate. If not, what was the degree of the departure from the standard?

I noted in my previous report I felt that the attempt to make a diagnosis was inadequate. I noted that [Mrs A] was known to have a high grade cancer of the breast and developed spontaneous severe pain that did not respond to standard analgesia. Under such circumstances further investigations with modalities such as bone scanning or MRI should have been carried out. In regard to the degree of departure from the expected standard of care I would grade this as moderate.

Whether the general medical team's failure to communicate to the oncology team about [Mrs A's] October/November 2007 admission is a departure from the expected standard. If so, what was the degree of that departure?

I have read the documentation provided by Waitemata DHB that pertains to the time in question (October/November 2007). There was a policy in place for referring patients to another service if required; in this case both the orthopaedic and pain services were contacted. However, the medical team did not deem that a referral to the oncology service was required. Although this is an omission, I would grade the omission as mild. However, I cannot find any documentation in the policies that sending discharge summaries to another service would be recommended. In this particular case the general medical team would probably have been aware that [Mrs A] was due to see an oncologist in the outpatients. [Dr B] (the general practitioner) explained [Mrs A] was unlikely to complain of back pain when she visited the oncologists because of her personality. Therefore a copy of the discharge summary would have alerted the oncologists to the recent admission. In 2011, most hospitals would have a clinical record where admissions and investigations would have been adequately documented and been easy to find. This may not have been the case in 2007. Lack of communication does not meet the appropriate standard of care. I would grade this as mild to moderate disapproval."

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