

Management of patients waiting for a first specialist assessment:

Responsibilities of DHBs, specialists and GPs

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The Health and Disability Commissioner, apparently for the first time, has recently prepared a report exploring the responsibilities of providers in the management of patients waiting for a First Specialist Assessment (FSA) in the public system. In particular, the Commissioner's report examines the relative responsibilities of DHBs, specialists, and GPs for the prioritisation and ongoing management of patients waiting for FSA appointments.

The Commissioner's report articulates the responsibilities of DHBs, specialists and GPs in clear and unambiguous terms. Whilst many of the Commissioner's findings on the law are restatements of existing legal and ethical obligations, the findings on specialists' obligations do contain new statements of law. This is a landmark report and one that demands careful consideration by all those involved in managing patients waiting for assessment and treatment in the public system.

Following a short overview of the background facts, this note sets out the key responsibilities of DHBs, specialists, and GPs, as identified by the Commissioner.

In June 2002 the patient, a 61-year-old man, visited his GP with urinary problems. The GP ordered a PSA test and referred the patient to a specialist urologist at the Urology Clinic of a public hospital.

Less than one month after the referral, the Urology Clinic wrote to the

patient, noting that the urologist would like the patient to undergo further investigations to obtain the clinical information needed to prioritise the patient for a FSA. The tests (including a flow test, ultrasound, and a further PSA test) were undertaken. The results were received by the urologist, and then summarised in a letter to the GP in September 2002. The urologist informed the GP that the patient had been prioritised as 'urgent' for a FSA at the Urology Clinic in view of his symptoms and the elevated PSA. The referral was backdated to the date of the patient's referral in June 2002.

Neither the patient nor the GP received any further communications from the Urology Clinic in relation to the referral and appointment for FSA. By April 2004, the patient's urinary problems were worsening, and the patient consulted his GP's locum. The locum noted the elevated PSA and, following an examination, urgently referred the patient to a private urologist. Biopsies revealed that the patient had adenocarcinoma of the prostate.

The patient had waited 22 months for his FSA, without being given an appointment time. The patient was in fact never seen at the Urology Clinic, and was not given any information about his clinical condition, options, or an estimate of the time within which he could expect to be seen (other than the initial 'urgent' prioritisation).

The task for the Commissioner was to consider the relative responsibilities for the prioritisation and management of the patient as between the DHB, the specialist, and the GP. The analysis in this note focuses on the general principles that emerge from the Commissioner's investigation.

Responsibilities of DHBs

Insofar as the responsibilities of DHBs are concerned, the following key principles can be identified:

- It is the DHB that bears primary responsibility for ensuring firstly, that a patient and the patient's GP are given clarity about when the patient could expect to be seen for a FSA, and secondly, that the patient and the GP receive information on waiting times
- In accordance with the Ministry of Health national service specification, DHBs have a duty to develop, implement and manage booking systems for all medical, surgical and diagnostic services. If a DHB cannot meet the ongoing demands for specialist assistance and advice within six months of referral, the DHB must:
 - prioritise referrals
 - notify referrers and patients of the ability or inability to provide services within the minimum standard of six months
 - provide referrers with information that indicates the level of need or priority that could be serviced

- provide referrers with referral or management guidelines to enable the GP to manage the patient's condition
- DHBs must have systems and procedures to monitor and review FSA waiting lists and referrals back to GPs for ongoing monitoring. This should include a 'bring up' or 'flag' alert to staff when referrals are not being met within the specified timeframe
- DHBs have a number of obligations relating to the provision of information. In particular:
 - if the number of patients to be seen for a FSA outnumbers the resources available, the DHB must advise the patient and the referring GP that based on the patient's current condition (as reported in the referral letter) either the patient will be seen for a FSA within six months, or the service is unable to see the patient for FSA within six months (with an explanation of the reasons for the ability to provide services)
 - the DHB must give the patient and the GP clear and specific advice about the option of seeking private assessment and treatment
 - the GP must be given any other information that will be helpful for managing the patient
 - the GP should be told to re-refer the patient if the patient's condition deteriorates, or if there is further relevant information available that would affect the patient's priority
- DHBs must not allow difficult relationships between management and clinicians to interfere with a DHB's duty to appropriately manage and monitor the FSA list. DHBs and individual clinicians have an obligation to work together effectively to ensure patients receive quality and continuity of care.

Responsibilities of specialists

The Commissioner's analysis of the urologist's conduct results in the fol-

lowing conclusions being drawn on the obligations of specialists in the prioritisation and management of patients waiting for FSA appointments:

- A specialist assumes responsibility for a patient for the purposes of establishing a duty of care when the information in the referral letter is considered by the specialist, and a priority allocated. It is not necessary for a clinician to see a patient for the duty of care to be established
- There is an obligation to only accept those referrals that can be seen within the resources available
- Referrals must be seen in order of priority
- It is the specialist's responsibility to prioritise patients in relation to all other patients awaiting FSAs
- Specialists have a responsibility to ensure that the process for assigning priority is appropriate. Simply adding patients to an ever growing list of patients awaiting a FSA, and assigning a high level of prioritisation, will be inadequate for a specialist to meet his/her responsibilities
- Once a patient has been prioritised, the specialist must ensure that the patient receives treatment in accordance with the assigned priority
- If a specialist provides a patient with information about the estimated time within which services will be provided, the specialist has a responsibility to ensure that it is an accurate estimate based on the specialist's knowledge of realistic waiting times.

Responsibilities of GPs

Insofar as the responsibilities on GPs for the management of patients waiting for a FSA are concerned, the following conclusions can be drawn from the Commissioner's report:

- A GP owes the patient a duty of care for the patient's clinical day-

to-day management pending the allocation of a FSA

- GPs have a responsibility to provide patients awaiting a FSA with relevant information including:
 - the right to be told about what other options are available to the patient, such as the right to seek private assessment and treatment if publicly funded services are not available
 - the right to be told relevant clinical details (for example, what an elevated PSA means)
 - the right to be informed of the risks of not being seen within the allocated prioritisation
- GPs have an obligation to take steps to actively follow up referrals and a patient's status on the waiting list.

Consistent with these conclusions of the Commissioner are the following ethical principles enunciated by the Medical Council in its Ethical Guidelines for Doctors' Duties in an Environment of Competition or Resource Limitation:

- Doctors have a responsibility, as advocates for their patients, to seek the provision of appropriate resources for the treatment of patients' needs
- Doctors should know how to access the services that are available to achieve the best outcome for their patients
- Doctors have a responsibility to advocate to the appropriate authorities for the provision of the range of services needed by the population, and report any deficiencies
- Where the best method of diagnosis or treatment can be identified but cannot be provided, doctors are advised to explain to patients what is optimal and what is available, and the consequences of taking the available course of action. The discussion should be documented
- Doctors who have been made to provide a service which they deem suboptimal must still inform

the patient of the optimal care and must advocate for its provision.

Comment

Much of the Commissioner's report is based on relatively established legal and ethical principles, including relevant case law, contractual obligations under DHBs' funding agreements with the Crown, and Medical Council guidelines. To this extent, the Commissioner's report provides a useful and unambiguous précis of the relative responsibilities of DHBs, specialists and GPs for the prioritisation and ongoing management of patients.

In our view, the new piece of medico-legal jurisprudence that emerges from the Commissioner's decision is in the Commissioner's statements on the responsibilities of specialists. In particular, it is the Commissioner's suggestion that the legal obligations of a specialist extend to ensuring that a patient is 'actually seen' for assessment in accordance with the assigned priority. Such an obligation may be considered by some to be imposing a high and perhaps overly onerous responsibility on a specialist, who might expect to have been entitled to rely on the administrative support within the DHB

for following up patients and actually ensuring patients receive treatment (whilst working cooperatively with the DHB to achieve this). The Commissioner's findings in this regard appear to rely on a Ministry of Health discussion document (*Aspects of a Doctor's Duty of Care*) prepared by Dr David Geddis. In support of imposing this high standard on specialists is the argument that it is the specialist who is in the best possible position, with his/her clinical knowledge, to ensure patients receive care in accordance with their needs, and take appropriate action if that is not possible.

A copy of the Commissioner's report (Case 04/HDC 13909) can be found on the Commissioner's website:
<http://www.hdc.org.nz/files/pageopinions/04hdc13909urologist,dhb.pdf>

Looking to the future

'Pacific health and the inequalities in our communities' health status have ensured a place for Pacific peoples as a core part of the health and disability sector's strategies and policies...

It is critical, as we continue our journey, to continue to learn from our past, to be unrelenting in our quest for better outcomes and to have high aspirations for what we may achieve.

In the future we will need to:

- embrace technology advancements
- develop our talent, workforce and leadership
- continue to invest in our organisations
- work closely with our communities
- involve the people who use our services in meaningful ways
- focus on excellence in service delivery and improving quality
- measure and monitor the effectiveness of our services
- continue to develop partnerships with mainstream organisations

Most of all we need to continue the extraordinary and wonderful work begun many years ago. We need to nurture the passion and commitment that sustain us.'

Pacific Health in New Zealand Our Stories. <http://www.moh.govt.nz/moh.nsf/0/6D9BA6B76EE8AE38CC256CD3000B2208>

Why are there cultural clashes?

'Physicians-in-training are part of a cultural group that has its own beliefs, practices, customs and rituals. These include definitions of health and illness; the superiority of technology; prevention through annual exams; compliance; procedure; and systematic approaches. Medical students engage in customs of professionalism and courtesy and have rituals like the physical exam, visiting hours and surgical procedures. Medical school teaches students scientific rationality and an emphasis on objectivity. Medical students value numeric measurement and physicochemical data and tend to separate the mind and body. Medical students reduce patients to individual diseases and body parts without seeing the patient as a part of a family or community. In this way, physicians in training represent an ethnocentric culture—one that values its own culture above others. This inevitably leads to conflicts with the patient's culture.

Medical students must have the capacity to assess themselves, to determine their own inherent culture's biases as well as their medical culture's biases. The realization of the influence that their own culture has on medical student's everyday behavior can help them understand the magnitude of cultural influences on their patient's lives and health behavior.'

<http://www.amsa.org/programs/gpit/cultural.cfm> (accessed 24 Sept 2006)