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When does a specialist assume the "duty of care" for a patient? The significance of Case 04HDC13909

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According to a recently realised decision by the Health and Disability Commissioner (HDC)[1] on the care of a urology patient at Southland Hospital, a specialist assumes the "duty of care" for a patient when they receive the referral letter.

This aspect of care has now been clearly defined, and it is important to most doctors practising clinical medicine. The Commissioner's report states:

> It is well recognised within the health sector that there is insufficient public funding to meet the immediate health needs of all New Zealanders. It is inevitable that not all patients who require treatment will be able to be seen, and some patients may spend a significant time period waiting to be assessed and treated in the public sector. In this environment, it is essential that patients waiting for assessment and treatment in the public sector receive appropriate care and management until such time as they are able to be seen.[1]

He then goes on to say,

> …[this decision] explores the responsibilities of providers in the management of patients waiting for a First Specialist Assessment ("FSA") in the public system. In particular, it examines the relative responsibilities for the prioritisation and ongoing management of patients waiting for FSA appointments, and the systems that should be in place to ensure that patients do not fall through the cracks.[1]

Many clinicians believe that the responsibility for not seeing the patient lies with the district health board (DHB) or Government for not providing the resources for the patient to be seen. They are right to a point, as the HDC report states:

> …under the Ministry of Health national service specification, DHBs had a duty to develop, implement, and manage booking systems for all medical, surgical, and diagnostic services. If DHBs could not meet the ongoing demand for specialist assistance and advice within 6 months of referral; the specification required DHBs to prioritise referrals; notify referrers and patients of the ability or inability to provide services within the minimum standard of 6 months; and provide referrers with information that indicated the level of need or priority that could be serviced, together with referral or management guidelines to enable general practice to manage the patient's plan of care and review or reassess the patient's condition as appropriate.[1]

However at the individual patient level the clinician has a responsibility that cannot be abdicated. This is what has been defined by the Commissioner in his report, when he states:

> A clinician does not have to be in direct contact with a patient to owe that patient a duty of care, and a clinician can accept a patient into his or her care without ever seeing that patient, 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, and a priority allocated.[1]

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The intriguing aspect of this HDC report is that the above statement is referenced to a discussion document released by Dr David Geddis—*Aspects of a Doctor's Duty of Care*.[2] This controversial discussion document appears not to have been accepted by many professional groups. Dr Geddis wrote this document for the Medical Advisers Group as a private individual before he started work for the Ministry of Health. It was firmly rejected by the Council of Medical Colleges and the New Zealand Medical Association who were both sufficiently concerned about the document for the Chairman to inform the then Director General of Health, Dr Karen Poutasi.[3] It is of great concern that this document, of uncertain status, has become a document of record because the Commissioner has used it as a critical part of his argument.

Of course the Commissioner is correct in going on to point out the reality of the system we work in with his comments:

> Doctors have a responsibility to ensure that the process for assigning priority is appropriate. Referrals to a service with limited resources should be seen in order of priority and a patient should receive treatment in accordance with his or her assigned priority. Prioritisation systems should be fair, systematic, consistent, evidence-based, and transparent.

These comments are entirely consistent with the New Zealand Medical Council's own statement on "Safe Practice in an Environment of Resource Limitation" of which some points are outlined below

(http://www.mcnz.org.nz/portals/1/Guidance/ethical%20guidelines%20doctors%20duties.pdf):

- A service has a duty to ensure that only those referrals that can be seen within the resources available (including time, staffing, and physical resources) are accepted.
- As far as possible, assessment should fairly establish the patient's priority for treatment compared to that of other patients.
- Doctors have a responsibility to ensure that the process of assigning priority is appropriate. Referrals to a service with limited resources should be seen in order of priority and a patient should receive treatment in accordance with his or her assigned priority. Prioritisation systems should be fair, systematic, consistent, evidence-based, and transparent.
- Doctors making a referral to a service he or she knows to be constrained should try to ensure that the referral contains all the information needed to ensure a fair assessment of the patient's priority.
- A doctor who receives a referral which does not contain the information required to make a fair assessment, should request the relevant information or return the referral to the referrer with a request for more specific information.
- All referrals must be met with a timely and appropriate response.
- A service or team making a decision about the management of a patient is responsible for the effects of making that decision.
- A doctor who has a patient in a booking system for treatment, should advise that patient, to the best of their ability, how long they could expect to wait for

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treatment and must notify the patient if his or her priority changes. It is acknowledged that managing acute services in conjunction with elective services can sometimes make this difficult. The booking system must be accurately portrayed and must not be misused to shift patients from a doctor's care.

However it now appears that the waiting-list situation may have deteriorated to the point where, despite patients being correctly prioritised, patients with significant degrees of illness can't get treated in the public sector in reasonable timeframes.

The previous Minister of Health stated in the NZMJ[4]:

> If DHBs are not providing timely services, they need to account to the Ministry of Health and the Minister for the reasons. Sometimes, for example, workforce shortages or industrial action make it more difficult, but DHBs are expected to take all action to meet their signed agreements with the Minister. At times, this can include use of the private sector…the Minister and Ministry can only take rapid action to address problems if they are kept informed of the latest issues…(The Minister) is keen for DHBs to be more proactive in terms of identifying potential problems so they can be averted.[4]

With this in mind, one of the most significant activities of the DHBs has been to remove patients from the waiting lists. A total of 8108 patients were removed from surgical waiting lists between January 2005 to January 2006.[5] In the last few months there have been many more reports of the removal of large number of patients from waiting lists. However the DHBs do not seem to be responsible on an individual patient basis—the doctor is—and a DHB's response is to remove people from the waiting list to fulfil the ministerial agreements about achieving manageable waiting lists.

The only time DHBs appear to become involved with individual patient care is when the patient complains via the media, their Member of Parliament, or the Minister of Health.

So, in summary, doctors have been made responsible for a job, without being given the tools to do it.

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