Cancer diagnosis

2015 (November) – Day 1, Q3

Medical Leader	✓
Medical Expert	•
Communicator	•
Advocate	•
Scholar	
Professional	•
Collaborator	
Manager	•

You are the Executive Director of Medical Service for a tertiary-level hospital. Your complaint investigator notifies you of a complaint from a woman who has presented with a missed diagnosis of malignancy and is terminally ill. In the process of investigating the recent presentation, the clinician found an unacknowledged histology result which was reported 18 months earlier as "strongly suggestive of malignancy". The patient and GP were unaware of this result, and on further investigation it has come to light that the patient had had a brief admission at the earlier time for elective surgery. At that time, the surgeon had observed some unusual tissue well away from the presenting problem and had biopsied it at that time. This was recorded in the operation note but the note had not been copied to the GP, and it was not mentioned in the very cursory discharge summary.

Further investigation reveals that the surgery had been performed by a surgical Fellow who had shortly after moved to another hospital to complete his experience in his chosen area of specialisation. The safeguard, of escalation of an unacknowledged lab result to the relevant Consultant / SMO had sat unacknowledged, along with another 183 results in his inbox. When you draw the situation to his attention he denies knowing it was his responsibility to check and clear his unacknowledged results inbox. You hear later from an RMO that the consultant concerned avoids using the computer delegating his tasks to RMOs.

Questions:

1. **What factors have contributed to this situation?**
2. **What are the medicolegal implications of this scenario?**
3. **What are the risks and how would you address them?**

Guidance for Censors

Contributing factors:
Failure of governance measures at multiple levels

- Failure of communication with patient, GP, and as part of effective handover – when biopsy was taken, by Fellow and writer of discharge summary (? An RMO)
- Failure of audit of communication to ensure a high standard is maintained
- Failure of checking of result, as part of that, failure of an existing safeguard (escalation to consultant)
- Failure of consultant to appreciate and act on his (or her) responsibility for care provided by all medical staff responsible to them, including the Fellow
- Failure of consultant to seek further training on how to use computer system (if relevant)
- Failure of clinical HOD to ensure governance standards being met within the service with periodic audit, incident review etc

Medicolegal implications:
Need to seek legal advice urgently

In NZ:
Complaints to Health and Disability Commissioner, some may be referred by HDC to Health Practitioners' Disciplinary Tribunal where individual practitioners may have failed in their professional responsibilities, outcome protracted, could end in loss of registration or restrictions being placed on practice. HR implications – may need to consider suspension or restrictions on practice at hospital level.

Risks and strategies to address them:
Invoke emergency response:

- Ensure patient has appropriate care and support, open disclosure, apology
- Urgent contact with GP, open disclosure to him/her and explanation
- Locate and inform Fellow, seek his co-operation in wider follow up and apology, advise him to notify his indemnifying organisation, offer support for him
- Urgent audit of adequacy of follow up and hand over of all patients cared for by Fellow
- Urgent audit of unacknowledged results within this service
- Clarification of consultant's responsibilities for all care provided by his team, with reference to disciplinary consequences of non-compliance
- Clarification of clinical HOD's responsibilities for adequacy of governance within service, including credentialing of short term appointees such as the Fellow

- Advice to surgeon and HOD to contact indemnifying organisation, applies also to EDMS

Assessment Rubric:

		Knowledge	Skills	Attitude/Behaviour
Poor	**1**	No recognition of wider issues beyond the patient concerned	Provides some specific actions but no indication of a strategy	Cannot convey own responsibility for oversight and resolution of incident
Limited	**2**	Focuses answer on open disclosure and patient complaints, mentions only some of relevant governance issues	Limited elements of a strategy, does not grasp significance of incident for entire hospital as well as Dept. of Surgery	Without seeing wider implications, sees own role only in context of affected individuals
Marginal	**2.5**	Covers care of patient, open disclosure, complaint management and other governance aspects but cannot describe other features of pattern of poor governance and implications Manages up May omit mention of key areas such as reputational damage, political implications, media coverage etc.	A strategy is described but deficient in some areas. Identifies appropriate sources of advice, recognises impact on affected staff	Appreciates wider implications but does not fully describe the widespread failure of governance. Prompts elicit more information but no clear overview.
Meets standard	**3**	Initiates appropriate management of patient and review most elements of good governance May need prompting for some aspects	Identifies importance of good communication with patient and GP	Recognises critical failures of governance at individual and service level, May see own role as leading management of entire incident
Good	**4**	Covers all aspects without prompting Recognises that there may be unacknowledged results in other services,	Mentions need for culture change Identifies lack of partnership with this patient in provision of her care Recognises need for support for staff whose actions have contributed to failings	Demonstrates a good grasp of multiple implications at all levels of organisation and of risks. Apportions responsibility for follow up appropriately while maintaining control of overall management of incident Recognises own deficiency in failing to ensure good governance in all services

Outstanding	**5**	Covers specifics of this situation, recognises risks across entire service and can provide succinct overview of strategy to audit, rectify, improve and bring about culture change within organisation	Develops wider themes e.g. the protection good communication and partnership with patients in their care provides against lapses such as this incident	Can present an exceptional overview of all aspects of incident for all of hospital Shows ability to lead a change in governance and culture in all levels of the organisation, starting with self