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

PATHOLOGY REPORT

2016 (November) – Day 2, Supplementary Question

You are the Medical Administrator of a regional public health service that contains a number of hospitals. You receive a call from a patient's lawyer, claiming that "one of your hospitals has chopped off my client's breasts for no reason because your pathologists are incompetent and she will be going to the media unless you offer substantial compensation, now". You say that you will need to gather information and get back to the lawyer. He replies, "You are just stalling".

After this call, you immediately contact the Acting Director of Pathology at the hospital who tells you that one of his anatomical pathologists believes that there might have been contamination of a biopsy sample leading to a patient being misdiagnosed with late stage breast cancer, and a radical mastectomy was undertaken. He says that this contamination was only noted at a multidisciplinary team meeting one month after the operation. The review of the removed breast tissue did not show any evidence of cancer. He also tells you that the patient was not notified, no incident report was submitted, and the issue was not followed up. He also relates that he was told by the surgeon involved, that one of the ward nurses might have disclosed the results of the post-mastectomy histology to the patient without permission.

Following this call you are collecting your immediate thoughts. You were aware that the anatomical pathology department has been dysfunctional for a while, has relatively low morale and that it has a poor reputation amongst the clinical staff. The hospital has been unable to recruit a permanent Head of Department for the past year.

Half an hour later, your PA tells you that a reporter from a television station is on the line waiting to speak to you.

Questions

1. What are the issues associated with this case?

2. How will you manage them, and in what priority order?

CENSOR NOTES

Issues:

- Urgent action required to manage media interest and associated risks, alerts to higher levels (CEO, Board, government), ensure support is being offered to patient by the service (not just by the patient's lawyer) and that involved staff also have support
- Detailed investigation required to establish facts, issues and required management of underlying causes and consequences – can be planned immediately but needs to be done thoroughly, not rushed, and candidate should not jump to conclusions
- Longer term requirements to address clinical governance structures, processes and culture, inter-professional relationships, professionalism of staff, including clinical leaders, and recruitment

Domains:

- Professional, Collaborator, Manager, Medical Expert, Communicator

Knowledge:

- Clinical governance – quality assurance principles and processes, incident management, open disclosure, just culture, accreditation standards, process analysis, workforce standards, quality improvement

Skills:

- Management of medico-legal issues
- Media management
- Pulling together serious incident investigation teams and overseeing investigation processes and outcomes, ensuring systems change
- Reporting up
- Managing inter-professional tensions
- Managing workforce gaps and demoralisation
- Performance management

Attitudes:

- Patient-first
- Open disclosure
- Just culture
- Learning from error

Score:		**Knowledge** Knows what to do	**Skills** Knows how to do	**Attitude/Behaviour** Shows s/he knows the consequences, leadership responsibility
Poor	1	An unstructured answer that lacks any sense of a coherent list of issues that need to be addressed: media management, detailed comprehensive investigation and long term plans for clinical governance and improving clinical culture.	An unstructured answer that lacks any sense of a coherent practical approach to the issues that need to be addressed.	Little or no consideration of importance of a patient-first culture, the consequences of good or poorly conducted open disclosure
Limited	2	Some understanding of clinical governance principles and processes, including management of major clinical incidents. Failure to mention issues including open disclosure, accreditation of clinical services, process analysis, workforce standards and QI.	Understands some of the potential underlying causes behind the scenario but fails to present these in a logical or structured manner. Fails to consider need to consult with peers and neglects the issues of managing up.	Needs prompting to mention a patient-centric approach. Knee-jerk responses to issues including assumptions not supported without good investigation and performance management. Failure to mention requirement to manage up as well as down or to seek advice from experienced peers.
Marginal	2.5	With or without prompting provides responses on most issues above but at a superficial level.	Begins with a practical approach but fails to provide clear prioritisation to actions. Abstract responses rather than a practical account of just how this scenario will be managed.	Starts with the patient but in a superficial way. With prompting mentions managing up and peer consultation but does not necessarily give the impression of being in control of the process.
Meets standard	3	Demonstrates knowledge in establishing a robust investigation and response process and include an appropriate initial response to the patient, lawyer and media. Issues of managing up to CEO / Board / Ministry. Medicolegal consultation.	Shows practical approach with prioritisation of tasks required. Immediate responses to the patient, lawyer and the media. Early meeting with patient and implementation of open disclosure process. First steps to managing up. First steps in establishing an investigation.	Puts the patient first in the response. Recognises that issues to do with governance and issues around clinical culture can be difficult to deal with. Defines responsibilities and accountabilities for action.
Good	4	As above plus consideration of independent external review of pathology reporting and safety standards; how to manage issues with performance management of individual clinicians.	Shows good insight into some potential risks in the management of this incident and how these risks might be minimised or managed. Mentions the importance of good change management processes.	In addition to the above, demonstrated empathy for staff affected by this incident and provides an insight as to how staff can be supported through a difficult public investigation.

Outstanding	5	High level response that demonstrates mature consideration of complexities and risk issues	Excellent, succinct and logical presentation which balances theoretical knowledge with practical operational response.	Good understanding of the factors that create and perpetuate poor clinical governance and culture, poor leadership. Identify that there may need to be multiple steps to achieve improvement.