Delay in receipt of bowel cancer test results and referral for chemotherapy (00HDC12383, 21 February 2002)

General surgeon ~ Public hospital ~ Bowel cancer ~ Histology ~ Information about results of procedures ~ Information about options ~ Rights 4(5), 6(1)(b), 6(1)(g)

A woman complained on behalf of her 58-year-old sister about the care provided by a general surgeon and a public hospital. The complaint alleged that:

1 the follow-up care after the woman's bowel surgery, a sigmoid colectomy to remove a malignant polyp, was inadequate as she was not given the results of the surgery or the prognosis until approximately six weeks later, and the treatment options were not discussed with her;
2 when the surgeon told the patient that the tissues removed contained cancer cells he advised her that if she wished she could have a scan in six months' time to see whether the cancer had developed further — however, no other treatment options were discussed with her; and
3 when the patient sought independent advice from her GP she was referred immediately for chemotherapy, by then eight weeks after her bowel surgery — the oncologist advised the patient that the chemotherapy should have commenced four to six weeks following surgery.

The Commissioner held that the patient was entitled to receive the results of the histology samples taken during her surgery without needing to specifically request them, and could reasonably expect to be told about oncology treatment. It was the surgeon's responsibility to satisfy himself, before going on leave, that suitable arrangements had been made for the patient to receive the information. He should have informed the GP about the patient's surgery, her treatment options, her histology results, and his plan for her ongoing management, and should also have informed the GP that he would be on holiday when the results became available, so that the GP could discuss them with the patient.

It was held that the general surgeon:

1 breached Right 4(5) in that he failed to enlist the GP's co-operation;
2 breached Right 6(1)(b) in that he left the patient "in the dark" at a time when she was vulnerable and needed all the information available about her treatment options; and
3 breached Right 6(1)(g) in that he failed to ensure that the patient received her results promptly.

The Commissioner recommended that the relevant Colleges review his report and consider how the reporting of the results of tests and procedures can be better co-ordinated to meet the needs of patients.