A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 03HDC02380)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Mr A	Consumer's husband
Dr B	Consultant Physician
Dr C	Consultant
Dr D	Medical Registrar
Dr E	General Practitioner
Dr F	Registrar for Consultant Physician Dr B
A Public Hospital	Provider

Complaint

On 13 February 2003 Mrs A complained to this Office about the standard of service provided to her by a public hospital. Mrs A's complaint was summarised as follows:

The hospital did not provide services of an appropriate standard to Mrs A. In particular, it:

- *did not follow up abnormalities apparent in the spinal X-ray report of 3 April 2002*
- *did not perform a bone scan as recommended by the spinal X-ray report of 3 April 2002.*

The hospital did not provide Mrs A with adequate information. In particular, the hospital:

- *did not inform Mrs A of the results of her spinal X-ray of 3 April 2002.*

An investigation was commenced on 25 March 2003.

Information reviewed

- Mrs A's general practice clinical records
- Mrs A's clinical records from the hospital
- A copy of Mrs A's ACC file
- Report from Dr B, consultant physician
- Report from the Quality and Risk Facilitator at the hospital

Information gathered during investigation

Overview

Mrs A was acutely admitted to the hospital on 7 March 2002 with severe abdominal and back pain. She was assessed by Dr C and Dr D, who ordered various tests and advised her that the scans showed no abnormality, but that her blood tests showed that there was a problem with her liver. Mrs A returned to the hospital's Outpatient Clinic and was seen by another doctor, who was concerned about her continuing back pain and ordered a lumbar X-ray. On subsequent visits to the Outpatient Clinic Mrs A asked Dr C and Dr D about the results of her X-rays, and was told that "there was no need to worry". When Mrs A's general practitioner ordered a further X-ray of her lower back in November she was found to be suffering from myeloma (cancer of the bone).

Background

Acute admission
On 7 March 2002 Mrs A was admitted to the hospital's Emergency Department with severe abdominal and back pain. A series of blood tests and an ultrasound scan of her liver and kidneys were performed. Mrs A was given morphine for pain relief, but as the scan did not detect any abnormality, her symptoms were provisionally diagnosed as being due to either renal colic or early appendicitis. When the results of Mrs A's blood tests revealed "grossly abnormal liver function" she was referred for medical review.

Mrs A was admitted to a medical ward under Dr C, a consultant physician. The following day she was examined by the senior house officer for Dr C. He reported that Mrs A was more comfortable and arranged for her to have a chest X-ray. The chest X-ray was reported as normal. Later that day Mrs A was reviewed by Dr C, who noted her scan and chest X-ray results. He arranged for Mrs A to have further blood tests.

Mrs A was discharged during the afternoon of 8 March. A Discharge Summary was sent to her general practitioner, Dr E, asking her to repeat Mrs A's liver function tests.

On 11 March Mrs A consulted Dr E because she continued to have back pain. Mrs A told Dr E that the doctors at the hospital had been unable to find the cause of her pain. Dr E thought that Mrs A's occupation as a piano teacher could be a contributing factor in her back pain and referred her for physiotherapy and acupuncture treatment.

18 March Outpatient Clinic appointment
On 18 March Mrs A was seen at the hospital's Outpatient Clinic by Dr F, registrar for consultant physician Dr B. Dr B and Dr C, as consultant physicians, shared admitting days at the hospital. Dr F recorded her assessment of Mrs A and noted that she had sudden onset of upper lumbar back pain, associated with recent heavy lifting. She ordered a lumbar spine X-ray and a series of blood tests, and arranged for Mrs A to return for a follow-up Outpatient Clinic appointment on 3 April.

Mrs A returned to see her general practitioner, Dr E, on 24 and 30 March with continuing back pain and was referred for further acupuncture treatment.

3 April appointment
Mrs A was seen on 3 April at the Medical Outpatient Clinic by Dr D, registrar for Dr C, for follow-up of her blood tests. She also had the spinal X-ray ordered by Dr F on 18 March. Mrs A told Dr D that her abdominal pain had settled but she had pain in one shoulder and in her lower back when twisting quickly. Dr D examined Mrs A's spine and found that there was no local tenderness and that she had full flexion and movement of her spine. He recorded that Mrs A had pain on twisting, no fever, night sweats or weight loss, and did not have any pain when at rest.

Dr D was unaware that Mrs A had seen Dr F on 18 March and that she had organised for her to have a spinal X-ray. The clinical records do not indicate the time that Mrs A had her X-ray on 3 April, but it is likely that Mrs A had the X-ray and blood tests performed before she saw Dr D, as she recalled that she asked Dr D about the results of her X-ray and he told her that "everything was fine with the X-rays". Dr D had looked again at the 7 March ultrasound films and discussed the films with the radiologist who originally read them. The radiologist confirmed that there was no abnormality of Mrs A's kidneys, liver or pelvis. When Mrs A asked Dr D about the results of her X-rays he assumed that she was talking about the films (taken on 7 March) that he had reviewed with the radiologist.

Dr D arranged for Mrs A to have a further scan and an Outpatient appointment in two weeks to review the scan and blood test results. He wrote to Dr E reporting his findings.

22 May appointment
At a subsequent Outpatient Clinic review on 22 May, Mrs A saw another doctor. (Dr D was on leave.) The doctor later informed ACC that he had never met Mrs A before he was asked to review her liver function tests and follow up on the ultrasound of 17 May at the Outpatient Clinic. Mrs A's liver function had improved and the ultrasound was normal. He said that when he questioned Mrs A about her general health he found that her main problem was back pain. He noted that the pain was in Mrs A's lower back; it was worse with bending but was improving. She also reported a spasm and cramp-like quality to the pain, but did not allow him to examine her, stating that the previous examination had been rough. The doctor concluded that, as there were no bowel or bladder problems, the cause of Mrs A's back pain was likely to be benign.

Follow-up by GP
On 5 July Mrs A returned to see Dr E again about her continuing back pain. Dr E informed me that she prescribed Mrs A a course of amytriptyline, an anti-depressant, on the advice of Mrs A's brother who is a doctor. Mrs A saw Dr E on 22 and 30 October to obtain ARC32 forms for continuing acupuncture treatment.

Mrs A consulted Dr E again on 4 November to inform her that her back pain was more severe and radiating into the pubic area and left side of her perineum. Mrs A also reported difficulty walking. Dr E ordered a spinal X-ray. The X-ray report of 6 November noted

there was a possibility of myeloma and that further investigation was warranted. Dr E ordered further investigations which confirmed that Mrs A was suffering from myeloma.

Dr E made enquiries with the hospital and found that the lumbar X-ray reported on 3 April (ordered by Dr F) noted:

> "Abnormal T9 vertebral body, which is the likely cause of the pain. This has fractured with loss of vertebral height. … A bone scan would be of use to find out whether other bony abnormalities are present."

Dr E was concerned that this report had not been noted or followed up by Dr C and Dr D when they saw Mrs A at the Outpatient Clinic.

Dr C informed ACC that he had only become aware of the lumbar X-ray and accompanying report in November when he received a phone call from Dr E. He said that when he looked through the notes in the presence of Mrs A's family he was unable to find the results of the X-rays in the notes. Dr C also stated:

> "Under the current clinical records filing system, the [Dr B] and [Dr C] registrar notes are filed under two different sections. Therefore it was likely that the two [Dr C] team registrars would look at the notes filed under a different section. If we had a system that filed all the notes under 'Internal Medicine', instead of the doctor's name, then the registrar seeing [Mrs A] would probably have read the previous registrar's note."

Additional information

The hospital
The hospital informed me that the reason that Mrs A was seen by Dr F at the 18 March appointment was that all medical admission patients presenting to the Emergency Care Centre (ECC), as she did on 7 March, were seen by any one of the three medical teams on duty in the department. The ECC clerks would identify which team had accepted the patient for assessment and produce identification labels. This would allow blood tests and X-rays to be ordered for the medical team. On this occasion it appears that the clerk understood that Mrs A had been admitted under Dr B's team but, due to workload balancing, Dr C's team assumed responsibility for Mrs A's care. The change was not communicated to the clerk and therefore new labels recording that Dr C's team was responsible for Mrs A's care were not provided. Some of the old/incorrect labels were left in Mrs A's clinical records and the labels were used in error on two occasions: first, when the outpatient appointment was ordered (this resulted in Mrs A being seen by Dr B's registrar, Dr F, who did not know her), and secondly, when Dr F ordered the lumbar spine X-ray.

The hospital stated that when Dr B's team received Mrs A's radiology report (dated 3 April 2002, recommending a bone scan) they sent it back to Clinical Records. Clinical records then forwarded the report to the Dr C team for sign-off. As noted above, Dr C stated that he did not see the report and it was not until he made enquiries in response to a telephone call from Dr E in November that he obtained a copy. A copy of the report is on file which is

annotated "To: [Dr C]" and is initialled with a signature that appears to be "…". There is no date indicated, therefore I am unable to establish when the report was sent to Dr C.

Dr C advised ACC that if Dr F had dictated a letter outlining her examination of Mrs A, copied to the Dr C team registrar, it would have alerted the registrars who saw her subsequently that X-rays had been requested. Dr E would also have been alerted. Dr C confirmed that under the current clinical record filing system the Dr B and Dr C registrars' notes are filed under two different sections, and it was unlikely for one team to look in the section allocated to the other team. He suggested that the system be changed so that all notes were filed under a section labelled "Internal Medicine" instead of a doctor's name, to prevent important information, as in Mrs A's case, being overlooked.

Follow-up actions
The hospital advised that it has taken the following actions in response to Mrs A's complaint:

> "We sincerely regret the series of systems glitches that contributed to the delay in [Mrs A] being identified as having a serious health problem. I know that [Mrs A] has had a difficult time and has received major therapeutic treatment over some months that must have been very exhausting and depressing. We're concerned for her and we're pleased to hear that she is having a good response to strong treatment.
>
> In December when we were made aware of the situation, [Mrs A] was very ill and we asked [Dr …, haematologist, who is her current primary care specialist] to advise us when he felt it would be appropriate to offer to meet with [Mrs A] to express our regret. At that time he believed she needed to concentrate on decisions relating to her treatment and he would let us know when she was ready. I will make contact again."

The hospital also informed me:

> "We [the hospital] have made a number of process changes in the past 12 months as part of quality improvement and risk management. …
>
> I advise that the changes we have made to our systems and processes include:
>
> 1. Patient allocation of new admissions
> 2. Generation of patient labels
> 3. Electronic sign-off of reports
> 4. Clinical Record processes
> 5. Booking and scheduling processes.
>
> Previously the patient came [into the hospital] and was allocated to one of the three medical teams on call. Sometimes the teams had uneven patient numbers admitted on a day, so the next morning patients could be re-allocated by the medical staff so that the numbers were more balanced. The medical staff did not always let the Admitting Department know in a timely manner, so new labels were not always generated promptly and it took a while for the Clinical Team to be changed in the system.

…

From July 2003 a new clinical information system has been installed which will allow all results to be electronically transmitted to the 'queue' of the consultant under whose care the patient is admitted. Instead of paper, the results will be able to be placed in the right place and the medical staff can view the results and sign them off without the possibility of delay or loss. If a clinical result is not for the patient under their care, they can send it back to the department generating the result to be checked and redirected appropriately.

… This applies to laboratory results not X-ray reports as yet (that will come later). The reason it is relevant is that, in [Mrs A's] case, … she had blood tests too. If the wrong ID labels were noted on the blood tests form, then this would be picked up earlier when the consultant (or registrar) did not sign the lab form and send it back. Corrections would have been made to the system earlier. This would correct the X-ray ID as well, which would mean that Dr C could have seen [Mrs A's] results earlier."

ACC
On 14 November 2002 Mrs A lodged a claim for medical misadventure with ACC against Dr D, Dr C, the doctor Mrs A saw while Dr D was on leave, Dr B and the hospital.

ACC informed me on 10 December 2003 that it is still investigating Mrs A's claim.

Referral to mediation
As a result of the information received from the hospital the Commissioner decided to refer the matter to mediation on 6 May 2003. The mediator advised the Commissioner on 22 May that Mrs A requested that the mediation meeting be deferred until after her treatment was complete. On 29 August the mediator advised the Commissioner that Mrs A wished to further defer the mediation until there had been a determination of her ACC claim. The Commissioner advised the mediator that the mediation could not wait for an ACC determination. On 26 September the mediator advised that Mrs A did not wish to proceed with the mediation.

Response to Provisional Opinion

The hospital responded to my provisional opinion as follows:

"We have received your provisional opinion and appreciate the opportunity to comment.

…

While we accept your findings in relation to the hospital, we have a few additional comments for consideration.

…

3. The comment on page 10 seems to suggest that there were doctors who did not see Mrs A because she was under the care of another team. Based on the details in the opinion this does not seem to be the case here. The junior doctors from the other team *did* see her, it is just that they did not have all the details. Although we have no problem in principle with your comment, we are concerned that it seems to relate to the actions of the particular staff in this case. The other medical team did see her and treat her, even though she was inadvertently referred to the wrong team for one clinic appointment. We accept however that medical staff should read all of the clinical information.

4. For the record, the statements we have provided are what we think happened, based on our piecing together the sequence of events. Because of the factual uncertainty and the possibility that further information might come to light later, we would like to ensure that it is understood that the details provided outline the events *as we believe them to be*. The lack of direct information, however, means that we cannot be entirely certain that this is what occurred. It seems to be the most likely explanation, but that does not make it 'factual'.

5. While we have co-incidentally made a number of information technology changes that we believe will reduce some of the system delays, the computerisation of radiology results is still not available electronically for medical staff to sign (as they can do for laboratory results). We believe however that the fewer pieces of paper that the medical staff must physically sign and that Clinical Records need to file, will make it easier to bring the paper reports to the attention of the medical staff in a more timely manner. Radiology reports remain still to be manually signed.

6. Follow-up actions:

   - Please find attached a letter of apology for [Mrs A].

   - We have asked for a review of the filing systems as requested. Action will be monitored by the relevant service quality manager."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

…

(f) The results of tests;

Opinion: Breach – The hospital

Follow-up of 3 April X-ray report
Mrs A complained that Dr C, consultant physician, and his registrar, Dr D, did not follow up the X-ray report of 3 April 2002, and did not perform a bone scan as recommended in the report.

Mrs A was admitted acutely to the hospital on 7 March 2002. All medical admissions to the Emergency Care Centre (ECC) at the hospital at that time were seen by any one of the three medical teams on duty in the department. The ECC clerks would identify the team that had accepted the patient and print the patient identification labels. The labels were placed inside the medical file for attaching to request forms for ordering such things as laboratory tests and X-rays. In Mrs A's case it appears that the ECC clerk understood that it was Dr B's team who had accepted responsibility for her care. However, because of workload balancing, another consultant physician, Dr C, assumed responsibility for Mrs A's care, and it was the Dr C team that managed Mrs A's care during her admission on 7 March 2002. This was not initially communicated to the clerical section, and only later were new labels generated for Mrs A for the Dr C team.

When Mrs A was discharged from the hospital on 8 March arrangements were made for her to return for a follow-up assessment at the Outpatient Clinic on 18 March. Some of the old/incorrect labels specifying that Mrs A was under Dr B's team were left in the clinical record and this information was used in error when the clinic appointment for 18 March was

arranged. This resulted in Mrs A being seen in the Outpatient Clinic by Dr B's registrar, Dr F, who did not know her and was unaware when she ordered the X-ray that the ID labels attached to the order form would result in the X-ray report being sent to the incorrect team.

Dr F noted that Mrs A had a sudden onset of back pain associated with heavy lifting and ordered a lumbar spine X-ray. Because Mrs A's abnormal liver function was the reason for her clinic appointment, Dr F also ordered repeat blood tests. Mrs A was given an appointment to return to the clinic on 3 April.

The clinical record filing system was arranged in such a way that the medical team registrars' notes were filed under two different sections under the individual doctor's name rather than a generic internal medicine section.

During the interval between the 18 March and 3 April appointments, the administrative error of the patient labels was identified, Mrs A's records were altered and she was reassigned to Dr C's team. By the time Mrs A returned to the hospital for the follow-up appointment on 3 April her team admission had been corrected and the identification labels amended, and she was seen by the Dr C team. The clinical records indicate that Mrs A did not have the tests ordered by Dr F until she returned for her follow-up Outpatient Clinic appointment on 3 April.

At the 3 April appointment, Mrs A was seen by Dr D, Dr C's registrar, for a review of her abnormal liver function. Dr D did, however, know that Mrs A had had an abdominal ultrasound on 7 March and, prior to seeing Mrs A he discussed further with the radiologist the findings of that examination (which had not shown any abnormality). When Mrs A asked Dr D for the results of her X-ray he replied that "everything was fine". Dr D did not know that Mrs A had been seen by Dr F on 18 March; that she had ordered a lumbar X-ray; that it had been performed on 3 April (presumably before he saw her at the clinic); and that a report was available. It is reasonable to assume that he thought that Mrs A was referring to the result of her 7 March ultrasound.

The results of the 3 April lumbar X-ray were sent to the Dr B' team registrar, who identified the mistake and returned the report to Clinical Records. Clinical Records noted that the report was intended for Dr C's attention and annotated it (without noting the date) for his attention. However, the first time that Dr C knew about the 3 April X-ray was when Dr E diagnosed Mrs A's myeloma in November and contacted Dr C to ask him about the X-ray. I have been unable to establish when Clinical Records identified that the report was for Dr C and forwarded it to him.

Right 4(4) of the Code gives every patient the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that patient. Because of an administrative error, the abnormality noted on Mrs A's lumbar spine X-ray of April 2002, and the radiologist's recommendation to proceed to a bone scan, was not noted until her general practitioner made enquiries in November. If the April recommendation had been noted and followed up, the diagnosis of bone marrow cancer and treatment may have occurred earlier than November.

The hospital acknowledges that a series of "systems glitches" led to Mrs A's spinal X-ray results not being communicated to her or followed up, and contributed to the delay in Mrs A being identified as a having a serious health problem. It believes, based on the information gathered, that the admission system was a contributing factor to Mrs A's situation, but was not the sole cause. The admission system error, as previously discussed, led to Mrs A being seen by the wrong team when she returned for her Outpatient Clinic appointment. A contributing factor was the other clerical system that resulted in the filing of doctors' clinical records under individual teams, which encouraged the doctors to access only apparently relevant information. As a result, Dr C and Dr D, who had been assigned to care for Mrs A, were unaware that she had been seen by one of the doctors from the other internal medicine team, who had ordered the X-ray, or that the X-ray was performed on 3 April. They therefore did not know to follow up on the recommendations contained in that X-ray report.

In these circumstances the hospital failed to provide services in a manner that minimised potential harm, and breached Right 4(4) of the Code.

Test results – 3 April 2002
Mrs A complained that Dr C and Dr D did not inform her of the results of her X-rays taken on 3 April 2002.

Right 6(1)(f) of the Code affirms a patient's right to information about his or her test results.

As previously discussed, when Dr B's team received Mrs A's radiology report they sent it back to Clinical Records. Clinical Records forwarded the report to the Dr C team for sign-off. The copy of the report sent to Dr C for his attention was initialled but there was no date to indicate when the report was sent to him. Therefore, I am unable to establish when the report was sent to Dr C. I accept his statement that he was unaware of the report until he was notified of its existence by Dr E in November and obtained a copy.

Dr C and Dr D could not respond to an X-ray report they had not seen. In my view, the reason that they did not inform Mrs A of the results of her lumbar X-ray was not because of negligence or lack of care, but because they were unaware that the X-ray had been ordered and performed.

However, the hospital had a responsibility to ensure that Mrs A's results were provided to her and the team responsible for her care. It was seven months before Mrs A received the results of her X-rays. This delay was unacceptable and amounted to a breach of Right 6(1)(f) of the Code.

Actions taken

- The hospital has reviewed its admission documentation systems and, on July 2003, a new clinical information system was installed. This new system provides for all results to be electronically transferred directly to the patient's consultant, so that the results will be able to be viewed and signed off by the team without the possibility of delay or loss, or returned for redirection if the patient is not known to that team. However, radiology results are not yet available and medical staff continue to sign off paper reports of radiology results manually.

- The hospital is undertaking a review of its clinical records filing systems in light of this case.

- The hospital provided a written apology, which has been forwarded to Mrs A.

Comment

The practice at the hospital for clinicians not to review or consider treatment provided by other medical teams (as identified by Dr C) raises issues under Right 4(5) of the Code, which affirms every patient's right to co-operation among providers to ensure quality and continuity of services. Junior doctors from both Dr C's and Dr B's teams at the hospital saw Mrs A. However, because of the systems in place at the time, it is possible that the doctors did not have access to all of Mrs A's details.

Communication between providers is fundamental to quality patient care. As has been demonstrated by this case, the absence of communication between different teams (even if both are practising the same specialty) can adversely affect patients.

I acknowledge that doctors are reluctant to "intrude" into colleagues' care. However, that practice serves no benefit – and is potentially harmful – when two doctors practising the same specialty of internal medicine do not take into account the treatment provided, and tests ordered by, another team. The hospital accepts that medical staff should read all of the clinical information.

Further actions

- A copy of this report will be sent to the Ministry of Health.

- A copy of this report, with details identifying the parties removed, will be sent to the Chief Medical Advisors of all District Health Boards and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.