Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902

Complaint

The Commissioner received a complaint concerning the treatment provided to a consumer at a hospital and health service by the oncology registrar and the consultant oncologist. The complaint is that:

In October 1996 the consultant oncologist did not record full and clear information about the planned level and frequency of radiotherapy for the consumer.

In addition, in mid-October 1996 the oncology registrar prescribed excessive levels and frequencies of radiotherapy for the consumer.

Further to this, the complaint is that between late October 1996 and early November 1996 the oncology registrar and the consultant oncologist provided the consumer with higher than intended doses of radiotherapy during treatment for cancer of the oesophagus.

Investigation

The complaint was forwarded to the Commissioner on 6 July 1998 by the Accident Rehabilitation and Compensation Insurance Corporation. An investigation was commenced on 13 September 1999 and information obtained from:

Complainant/Consumer's wife
Consultant Oncologist/Provider
Oncology Registrar
Business Manager, a cancer centre
Chief Executive Officer, hospital and health service

Medical records relating to the treatment of the consumer were obtained and reviewed as were the policies and procedures relating to prescription of radiotherapy. The Commissioner sought advice from an independent radiation oncologist.

Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902, continued

Information Gathered During Investigation

Background

The consumer was diagnosed as having adenocarcinoma of the distal oesophagus (malignant tumour of the furthermost part of the gullet) in early September 1996. He was referred for consideration of surgery but CT scanning suggested a 9cm long lesion, therefore the consumer was assessed as not suitable for any surgical treatment.

Radiotherapy

In mid-October 1996 the consultant oncologist saw the consumer during a clinic at a hospital and health service (HHS) where the decision was made to proceed with pallative radiotherapy to the oesophagus. The consultant oncologist's clinical notes of this consultation stated:

> *To proceed therefore with pallative radiotherapy to the oesophagus. Options are 20gy in five fractions or 27gy in six fractions treating three times per week.*

The consultant oncologist filled in a Radiotherapy Planning Request Form and completed the section "*Fractionation*" by writing "*27/6 or 20/5*". The consultant oncologist stated to the Commissioner that his note "*27/6*" meant "*26gy to be administered in 6 fractions treating 3 days per week over two weeks*" and his note "*20/5*" meant "*20gy in five fractions daily*". The consultant oncologist stated he did not complete this form more fully as he intended overseeing the treatment himself and initialled the "*To be planned by*" box to indicate this. The consumer was given a priority "*C*" rating, meaning treatment was not required urgently.

Continued on next page

Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902, continued

Information Gathered During Investigation *continued*

Two days later the oncology registrar, met with the consumer. The oncology registrar reported to the Commissioner that when she saw the consumer she did not have access to the consultant oncologist's clinic notes. The practice at the time was for the typing to be completed at the HHS on the day of the clinic, and then sent to another hospital for signing, usually arriving there two days later. Therefore the oncology registrar had access only to the consultant oncologist's radiotherapy planning request form. The oncology registrar stated to the Commissioner that "*As the form did not specify any specific time interval between doses, I had no reason to believe that the fractionation was other than on a daily basis".* The oncology registrar prescribed 27gy to be given daily in six treatments of 4.5gy, not six treatments on three days per week over two weeks as the consultant oncologist intended. The oncology registrar stated to the Commissioner that the departmental protocol did not require that the prescription be counter-signed.

The consumer's film and prescription were reviewed at a departmental planning review meeting in late October 1996. The consultant oncologist was absent from this meeting due to other commitments.

The consumer's radiation treatment was commenced five days later and completed in early November 1996.

Over the following months the consumer developed symptoms suggestive of persistent or recurrent disease within the oesophagus. He developed altered sensation, weakness and sphincteric disturbance compatible with radiation-induced myelopathy (damage to the spinal cord).

When the error was recognised by an Oncology Unit, new policies were introduced to reduce the possibility of registrar prescription errors. Registrars can no longer prescribe radiation therapy without counter signature by a Consultant Oncologist.

Continued on next page

Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902, continued

Information Gathered During Investigation *continued*

The consultant oncologist discussed the error with the consumer, as documented in his letter to the consumer dated late September 1997. In this letter the consultant oncologist stated:

> *"You were therefore treated to an incorrect dose which is in excess of the amount we use. It is well recognised that an overdose of radiation to the spinal cord, which is the major nerve pathway that carries all messages from your brain to the rest of the body, can lead to damage to the nerves, usually only demonstrating itself after a nine month or more delay from completion of treatment. There are usually no early warning signs of such damage. ... In the absence of any other obvious cause of nerve damage, therefore, I must conclude that your leg weakness and alteration of sensation is due to the overdose of radiation ... My advice to you is to proceed with an ACC Claim for whatever support and compensation you require as a consequence of the radiation damage you have experienced."*

The consumer died in March 1998.

In its decision of late April 1998 the Medical Misadventure Committee of the Accident Compensation and Rehabilitation Corporation (ACC) found that medical error had occurred.

Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902, continued

Advice to the Commissioner

During the course of this investigation I received the following advice from an independent radiation oncologist:

> *"...* [The consumer] *was seen at a peripheral Hospital and the planning request form was filled in appropriately. Despite having a non-urgent priority for planning and treatment the Radiation Therapists arranged a planning appointment within two days. Their enthusiasm for treating patients with symptomatic cancer within the earliest feasible time frame is to be commended but in this case* [the consumer's] *notes were not available for the appointment. If* [the oncology registrar], *when faced with the situation of having to plan a patient whom she had not met before and for whom she did not have the notes, had sent him back home, this man with major symptomatic malignancy would have had a long car journey unnecessarily. This would have reflected badly on the hospital as well as posing a significant physical discomfort on* [the consumer]. *If* [the] *Unit at that time had a similar protocol to all other New Zealand Oncology Centres and did not allow Registrars to prescribe radiation therapy without a counter signature by a Consultant Oncologist this dose would not have been given. If, when* [the consumer's] *case was presented at a review session,* [the consultant oncologist] *had not been performing a peripheral clinic the error would have been detected. Multiple steps in the pathway lead to this patient receiving the incorrect dose."*
>
> *"The completion of the planning request form is to provide basic data to allow Radiation Therapists to arrange an appointment and schedule a potential treatment start date. It is not usual policy for the treatment request form to contain any more details than* [the consultant oncologist] *provided. I emphasise that this is not a treatment prescription. Comprehensive notes were dictated at the peripheral clinic but were not available for the planning session.*"

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Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902, continued

Advice to the Commissioner *continued*

My advisor further commented that:

> *"Having detected the error have* [the consumer and the consumer's wife] *received information and care at the expected high standard?* [The consultant oncologist's] *honesty in dealing with* [the consumer] *is acknowledged. He offered a very high standard of care once the spinal cord overdose was recognised."*
>
> *"When the error was realised new policies were introduced at the* […] *Oncology Unit to significantly reduce the possibility of Registrar prescription errors. Registrars can no longer prescribe radiation therapy without counter signature by a Consultant Oncologist. These guidelines are very strict and clear."*

The oncology registrar's role in prescribing radiation treatment:
The Commissioner's expert advised that:

> *"*[The oncology registrar's] *prescribed radiation therapy that led to a disabling spinal cord injury in a man who had an advanced malignancy. Whilst his life expectancy was not altered the quality of his life deteriorated as a consequence of that injury.* [The oncology registrar] *was only a junior Registrar and yet was entitled by her department management to prescribe radiation therapy. Whilst she is responsible for the prescription, the departmental policies and failure of error trapping procedures contributed to this event."*

Response to Provisional Opinion

The Commissioner's provisional opinion was sent to the hospital and health service and the oncology registrar for comment. In response the Chief Executive Officer of the hospital and health service stated "[The hospital and health service] *has read and considered the provisional opinion on the complaint made by* [the consumer's wife]. *We acknowledge that it is a fair opinion.*"

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902, continued

Opinion: No Breach – Consultant Oncologist

In my opinion the consultant oncologist did not breach Right 4(1). I accept that the planning request form for radiation treatment was adequately completed by the consultant oncologist and that this form should not have been used as a prescription for treatment.

On discovery that the consumer had received an overdose of radiation, the consultant oncologist was forthright in dealing with the situation and provided a high standard of support and care to the consumer.

Opinion: Breach – Oncology Registrar

I note that the oncology registrar was adhering to the current policies of the Oncology Unit which allowed registrars to prescribe radiation treatment. I am advised that this policy was at variance with other oncology services in New Zealand at the time. I also accept that the oncology registrar should not have been placed in the position of prescribing the consumer's radiation therapy regime without supervision from a consultant.

However, in my opinion the oncology registrar breached Right 4(1). Ultimately she was responsible for the prescription of the radiation therapy and failed to show reasonable care and skill in providing this treatment. The oncology registrar relied solely on the planning request form completed by the consultant oncologist in prescribing the consumer's treatment. In my opinion the oncology registrar should at least have reviewed the consultant oncologist's notes or consulted the consultant oncologist himself prior to commencement of the course of treatment. The oncology registrar's failure to do so indicates a lack of reasonable care and skill and, in my opinion, is a breach of Right 4(1) of the Code.

Opinion: Breach – Hospital and Health Service

Employers may be vicariously liable for employees breaches of the Code under section 72(1) of the Health and Disability Commissioner Act 1994. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing which breached the Code.

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Oncology Registrar/Consultant Oncologist/Hospital and Health Service

Report on Opinion - Case 98HDC15902, continued

Opinion: Breach – Hospital and Health Service *continued*

The hospital and health service Oncology Unit did not have the appropriate policies in place to prevent the error whereby the consumer received an overdose of radiation treatment. The oncology registrar, a junior registrar, should not have had the sole responsibility of prescribing the consumer's radiation therapy regime. Nor were appropriate policies in place to detect dosage errors before the commencement of radiation therapy.

In these circumstances, in my opinion the hospital and health service did not take reasonably practicable steps to prevent the oncology registrar's breach of the Code. The hospital and health service is therefore vicariously liable for the oncology registrar's breach of Right 4(1).

I acknowledge that, as soon as the oncology registrar's error was brought to the hospital and health service management's attention, new policies were formulated and implemented to prevent a similar error recurring.

Actions

Hospital and Health Service
I recommend that the hospital and health service:

- Provides a written apology to the consumer's wife for breaching the Code of Rights. This letter is to be sent to my Office and I will forward it to the consumer's wife.

I recommend that the oncology registrar:

- Provides a written apology to the consumer's wife for breaching the Code of Rights. This letter is to be sent to my Office and I will forward it to her.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand.

An anonymised copy of this opinion will be sent to the Royal Australasian College of Physicians and the New Zealand Medical Radiation Technologists Registration Board for the purposes of education.