DR C /

A PUBLIC HOSPITAL

A Report by the

Health and Disability Commissioner

(Case 00HDC12383)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Dr C / A Public Hospital

Parties involved

Ms A	Complaint / Consumer's sister
Mrs B	Consumer
Dr C	Provider / General Surgeon
Ms D	Chief Executive Officer / Public Hospital
Mr E	Medical and Surgical Services Manager / Public Hospital
Dr F	General Practitioner to the Consumer
Mr G	Medical and Surgical Services Manager / Public Hospital
Dr H	Oncologist / Neighbouring Public Hospital
Dr I	Oncology Registrar / Neighbouring Public Hospital

Complaint

On 24 November 2000 the Commissioner received a complaint from Ms A on behalf of her sister, Mrs B. Ms A had complained previously to the public hospital specifying that she did not want her sister involved with the complaint. On 11 January 2001, after consultation with my Office, Mrs B agreed to support the complaint that:

- *In December 1999 Mrs B had surgery performed at a public hospital by Dr C. Dr C removed a polyp and Mrs B required further bowel surgery. Mrs B's follow-up care was inadequate following her bowel surgery, as she was not given the results of the surgery or its prognosis. The treatment options were not discussed with her until February 2000.*
- *In February 2000 Dr C told Mrs B that the tissues removed contained cancer cells. Dr C advised Mrs B that if she wished she could have a scan in six months to see if the cancer had developed further. No other treatment options were discussed with Mrs B.*
- *Mrs B sought independent advice from her general practitioner and was referred immediately for chemotherapy, which was then eight weeks after her bowel surgery. The oncologist advised Mrs B the chemotherapy should have commenced four to six weeks following surgery.*

An investigation was commenced on 12 January 2001.

On 19 February 2001 Dr C, following the receipt of his investigation letter, contacted my Office to ask whether he could meet with Mrs B to try to resolve the issues with her directly. Mrs B agreed to this meeting with advocacy support.

Dr C / A Public Hospital

On 13 March 2001 Mrs B and Advocacy Services supported by advocates, met with Dr C at the public hospital. On 29 March 2001 Advocacy Services advised me that the matter had not been resolved to Mrs B's satisfaction. I therefore decided to continue my investigation. Mr C and Ms D, Chief Executive Officer, of the public hospital, were advised of this on 9 May 2001.

On 9 May 2001 the public hospital was advised that the complaint also included the following:

A complaint was made on Mrs B's behalf directly to the public hospital in the first instance. The public hospital took too long to respond to the complaint and the letter from Mr E was inadequate because it did not address the issues raised.

Information reviewed

- Mrs B's medical records from the public hospital
- Mrs B's medical records from her general practitioner, Dr F.

Information gathered during investigation

On 2 November 1999 Mrs B consulted her general practitioner, Dr F, because she had blood in her bowel motion. Dr F referred her for a barium enema (report dated 19 November 1999) and the results became available to him on 22 November 1999. This investigation revealed a probable malignant polyp in Mrs B's large bowel. The radiologist, recommended a colonoscopy. Dr F spoke with Mrs B about these results and referred her to a public hospital on 23 November 1999. His referral letter was marked 'urgent'.

On 1 December 1999 Mrs B saw Dr C at the public hospital about the colonoscopy. On 17 December 1999 Dr C wrote to Dr F informing him that there were malignant changes in the polyp and that he had talked with Mrs B about the results and advised her that surgical removal was indicated. In his letter to Dr F, Dr C stated: "I have discussed the operation and potential problems with an anastomic leakage. She will of course require ongoing surveillance following this and further follow-up as far as the carcinoma is concerned will depend on the staging."

Dr C / A Public Hospital

On 20 December 1999 Mrs B was admitted to the public hospital and had a removal of the sigmoid colon (part of the large bowel) the following day. There is no record of Dr C seeing Mrs B until 25 December 1999. Dr C assured me that it is his practice to review all of his patients in hospital at least daily, including on weekends. Mrs B's records indicated that on 26 December the drain, which normally keeps the wound dry, had slipped into Mrs B's abdomen. Dr C performed further surgery to remove it on 27 December. Mrs B seemed to suffer no adverse reaction to the second operation. Dr C saw her on 28 December and Mrs B was discharged from the public hospital on 29 December 2000. Dr C's discharge summary is as follows:

> "The findings at operation were those of a small ulcerated carcinoma of the distal sigmoid colon with no evidence of any spread. A standard sigmoid colectomy was performed with a primary anastomosis."

There is no indication that this letter was sent to Dr F. The letter was not 'cc'd' to Dr F and there is no copy in his records. Mrs B's nursing notes indicate that she was referred to Community Services for home help. Mrs B had not received the laboratory results at the time she was discharged from the public hospital.

The specimen taken during surgery on 21 December was received at a laboratory on 23 December 1999. The laboratory issued its biopsy report on 30 December 1999, the day after Mrs B was discharged from the public hospital. The public hospital received the report on 31 December 1999. There is no indication that the laboratory sent a copy of the histology report to Dr F. The report was not 'cc'd' to Dr F and there is no copy in his records. The laboratory advised me that its policy is to send copies of laboratory reports to the patient's general practitioner if this information is stored in the laboratory's patient management system. There are several ways general practitioners can obtain laboratory results. General practitioners can telephone for laboratory results on an 0800 telephone line or, if they have electronic link access, through the 'ÉCLAIR' computer laboratory result line, or by direct contact with the hospital and health service's GP Liaison Service.

Dr C advised me that Dr F was listed as Mrs B's general practitioner. If a copy of the report had been sent to the public hospital, he would have expected a copy also to have been sent to Dr F. There are a number of possible reasons why a copy did not reach Mrs B's general practitioner, for example the report could have been misfiled.

On 10 January 2000 Mrs B consulted Dr F because she had not received any report about the extent of the cancer. Dr F recorded: "discussion re histology results. See [Mr C] one month." Mrs B told me that she contacted Dr F to

obtain the results of her surgery. She recalled that Dr F tried to contact Dr C but he was on holiday.

Dr C advised me that he was on leave during the month of January and there was no locum cover. He was unable to delegate Mrs B's consultation while he was away. He also informed me that hospitals the size of the public hospital do not have registrars or resident medical officers who are experienced or senior enough to undertake patient consultations of this type. Dr C concluded:

> "The period therefore before her surgical follow-up was longer than one would regard as being ideal and I would normally see the patients in this position after a period of about two weeks after their discharge. As a copy of the histology report is sent to the general practitioner and her own practitioner will have received his copy in the early part of January, it may have been appropriate for him to have discussed this with her."

On 4 February 2000 Mrs B saw Dr C. Following the consultation Dr C sent the following written advice to Dr F:

> "The histology on the sigmoid colon show a rather poorly differentiated adeno carcinoma which pushes into the muscularis propria but not through it. Unfortunately there were two lymph nodes close to the bowel wall which were infiltrated with tumour. However the rest of the glands were clear.
>
> I have explained this to [Mrs B] and her husband with the alteration in her statistical prognosis because of the lymph node involvement.
>
> I plan to keep her under colonoscopic surveillance in the meantime and will do her next colonoscopy in two years time. At present she and her husband are going to decide whether they want ongoing surveillance follow-up as far as the carcinoma is concerned which will take the form of CEA determinations and the CT scanning.
>
> I will see her again in six months just to check her progress then and also to initiate surveillance if that is what she wants."

On 7 February Mrs B consulted Dr F because she was not satisfied with Dr C's explanation and because he did not offer her any other treatment option. Dr F documented in Mrs B's notes: "7 February 2000. Wishes to discuss [Dr C's] decision. Discussion with [Dr H] and he will see her on 14 February 2000." Dr H is an oncologist at a neighbouring public hospital. On 16 February Dr I, oncology registrar, informed Dr C and Dr F:

> "We met with [Mrs B] today to investigate the role of adjuvant chemotherapy. In this setting of Duke's C colon cancer there is potentially a 40% risk of systemic metastases. We would expect that adjuvant 5FU and Leucovorin given over six months will result in a 30% reduction in the incidence of recurrences.
>
> After explaining the expected toxicity of the treatment [Mrs B] is happy to go forward for this. We will organise routine bloods, chest x-ray, and CT abdomen and pelvis prior to reviewing [Mrs B] next week to commence her first week of 5FU and Leucovorin. Subsequent to this we hope to be able to organise her further chemotherapy [in the public hospital]."

Ms A told me that she and her sister attended this consultation with Dr H and Dr I. Dr H told them chemotherapy was the preferred treatment option in cases such as Mrs B's and should commence four to six weeks after surgery. At the time of the appointment Mrs B had had surgery eight weeks previously.

With regard to the normal role of chemotherapy in the treatment of cancer of the bowel, Dr C advised:

> "It is my normal practice to discuss the option of adjuvant treatment where indicated. I was concerned at the consultation about a complication which had occurred after her bowel resection where a drain had fallen back into the abdominal cavity requiring a further exploration. This had not occurred in my experience before and I was upset about the incident and the need for further procedure in order to correct this. I did not mention an oncology referral at the time. I can only put it down to the distraction of discussing the complication. She was however subsequently referred via her own doctor and received her chemotherapy within the therapeutic window. Her outcome has not been significantly altered by the timing of her chemotherapy."

Mrs B told me that there is a need for co-ordination and open communication between all units – surgery, oncology and radiology – involved with patient care. In her view, copies of histology reports should automatically be sent to oncology units for their action and advice. Dr C supports that view and advised the following:

> "As all of our histology reporting is done through [the laboratory] in [the neighbouring public hospital], it may be helpful for copies of cancer histology's to go to the Oncology Unit for information and action. This would back up the current system and provide a further safeguard."

Dr C / A Public Hospital

On 24 April 2000 Ms A wrote directly to the public hospital with her complaint about her sister's care. She advised Ms D, Chief Executive Officer, that the complaint was her own initiative and she did not want her sister contacted or involved in any of the issues raised. Her concerns hinged upon two issues:

> "1. Lack of follow-up care, resulting in an unacceptable length of time before results, prognosis and treatment options were discussed.
> 2. Inadequate and inaccurate advice about treatment options on the part of [Mr C], indicating the lack of a specialist referral."

On 27 April 2000 Ms D responded to Ms A advising her that Mr E, Medical and Surgical Services Manager, would conduct an investigation into her complaint. Ms D indicated that she would not be able to respond directly to Ms A without Mrs B's permission. Ms A's letter requested that her sister not be consulted about this complaint.

Mr G, Risk Quality Manager, advised that Mr E made several attempts to contact Ms A by telephone, but he was told Ms A was either on leave or not at work. He left messages with her employer to call him, but he did not hear from her. His reason for telephoning was to obtain more information so that he could investigate further and reach a satisfactory resolution.

On 22 November 2000 Ms A had not received any further information about the complaint or outcome of the investigation. Ms A telephoned Mr E. Mr E listened to her concerns but did not indicate any formal process had been or would be followed. He undertook to have a word with the surgeon. On 27 November 2000 Mr E wrote to Ms A as follows:

> "Following up on your recent letter and our subsequent telephone conversations I am happy to provide you with an update on the issues that you raised.
>
> In our last conversation the two issues that you wanted some feedback on were, that there had been no follow-up of your mother [sister] over Christmas and secondly that [Mrs B] was advised to return to see the surgeon within six months, however she chose to attend [a neighbouring public hospital] for oncology treatment.
>
> As previously indicated I am unable to of course discuss any specifics of this case, however I am happy to provide you with some general feedback. I can assure you that over Christmas [Mrs B] was followed up and was on consistent treatment. She was in fact in hospital for a significant part of the Christmas period under the care of our general surgeons.

> In terms of her treatment for oncology, the treatment regime that she was under at the public hospital was the accepted and normal practice for patients with her particular condition. Her treatment was discussed fully with her at the time and an agreement was made in regards to appropriate follow-up times.
>
> It is a choice of any person to seek alternative or additional treatments, in this case [Mrs B] chose to undertake a course of oncology at [a neighbouring public hospital].
>
> [The neighbouring public hospital] has been in constant contact with her general surgeon and we have been working together in continuing [Mrs B's] treatment.
>
> We have reviewed [Mrs B's] case and can find no omission in her treatment and it appears entirely appropriate. As recently as August [Mrs B] has again had a follow-up session with the general surgeon and they have agreed on a course of action both in the short term and in the medium term.
>
> If there is any further questions or queries regarding this please do not hesitate to give me a call."

On 12 December 2000 Ms A advised me that this letter did not address her concerns. After consultations with my Office on 11 January 2001 Mrs B agreed to be involved with the complaint. However, Ms A and Mrs B were anxious about the possibility of Mrs B's future care being compromised. This matter was raised at the advocacy meeting on 13 March 2001. Ms A and the two advocates considered that the public hospital had taken too long to respond to Ms A's letter and failed to address the issues she raised. On 19 June 2001 Mr G responded to my investigation on behalf of the public hospital. Mr G sent a copy of the public hospital's complaints procedure and advised me that it was reviewed in February 2001.

Dr C / A Public Hospital

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

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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 –

…

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;

…

g) The results of procedures.

RIGHT 10
Right to Complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

Dr C / A Public Hospital

Opinion:
Breach
Dr C

In my opinion Dr C breached Right 4(5) and Rights 6(1)(b) and (g) of the Code as follows:

Rights 6(1)(b) and (g)

Mrs B had the right to all the information that a reasonable patient in her situation would expect to receive about her treatment options in order to make an informed choice about her treatment. Mrs B was also entitled to receive the results of the histology samples taken during her surgery. Right 6(1) of the Code gave Mrs B the right to receive this information without needing to specifically request it.

Oncology treatment was clearly an option for Mrs B. Mrs B could reasonably expect to be told about oncology treatment. In Mrs B's mind this treatment should have commenced four to six weeks after her surgery. Dr C did not give Mrs B this information when he saw her in February 2001. He left her in the dark at a time when she was vulnerable and needed all the information available about her treatment options. Accordingly, in my opinion Dr C breached Right 6(1)(b) of the Code.

Mrs B knew that she had had surgery to remove her bowel cancer, but when she left hospital she did not know whether the cancer had invaded other tissue. This information was contained in the histology report which became available the day after Mrs B was discharged from the public hospital. Dr C informed me that it is his practice to inform his patients about their histology reports at his first post-surgery consultation with them, about two weeks after their discharge from hospital. He could not inform Mrs B about her results because he was on holiday. Dr C gave Mrs B her results on 4 February 2001, which was six weeks after the results were reported. In my opinion it was unreasonable to expect Mrs B to wait such a long time for such crucial information. Dr C left Mrs B to speculate and worry about the results of her histology. In my opinion, by failing to ensure Mrs B received her results promptly, Dr C breached Right 6(1)(g) of the Code.

Right 4(5)

Mrs B had the right to expect all her health care providers to work co-operatively to ensure that she received well co-ordinated, good quality health care.

Mrs B was not given her results because Dr C was on holiday. Dr C assumed that Dr F would receive the histology report and would contact Mrs B with the result. Dr F did not receive Mrs B's discharge summary or her histology report. He was therefore at a disadvantage when Mrs B came to see him on 10 January 2001. He was also unaware that Mrs B had not been informed about her treatment options. She informed him of this when she came to see him on 7 February.

Dr C told me that it might have been appropriate for Dr F to give Mrs B this news. Dr F tried to get Mrs B's results on 10 January. It was then that he learned Dr C was away. It was Dr C's responsibility as her surgeon to satisfy himself, before going on leave, that suitable arrangements had been made for Mrs B to receive the information. Dr C should have informed Dr F about Mrs B's surgery, her treatment options, her histology results and his plan for her ongoing management. Dr C should also have informed Dr F that he would be on holiday when the results became available and asked Dr F to arrange to discuss them with Mrs B. Dr C failed to enlist Dr F's co-operation and, in my opinion, therefore breached Right 4(5) of the Code.

The Public Hospital

In my opinion that part of the complaint that relates to the hospital and health service's failure to respond to Ms A's complaint is outside the scope of the Code of Health and Disability Services Consumers' Rights. My reasons for that conclusion are as follows:

Right 10 gives the consumer the right to make a complaint in any way the consumer sees fit. Ms A was not the consumer in this instance. Although she made her complaint for her sister, who was the consumer, she did not make the complaint as agent or on behalf of Mrs B. Ms A was quite clear when she initiated the complaint by writing to the public hospital that she did not want her sister involved. Accordingly, Ms A's complaint was not one to which Right 10 of the Code applied.

However, in my view Ms A's letter raised serious issues concerning the quality of care her sister received. The public hospital could and should have taken the opportunity to investigate the issues raised to improve the quality of care in the event that Ms A's complaint was found to be justified. I recommend that the public hospital review its complaints handling and quality assurance procedures to ensure that such complaints are properly followed up in future.

Dr C / A Public Hospital

Actions

I recommend that Dr C take the following actions:

- Apologise to Mrs B for his breach of the Code. This letter is to be sent to my Office and will be forwarded to Mrs B.
- Review his practice in light of this report.

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

Further comment

I note the suggestion from Mrs B and Dr C that histology reports should be copied to Oncology Departments for their advice and input. I recommend that the relevant Colleges review this report and consider how the reporting of the results of tests and procedures can be better co-ordinated to meet the needs of patients. To this end, an anonymised copy of this report will be sent to the Royal Australasian College of Pathologists, the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, the Royal New Zealand College of General Practitioners, and the Cancer Society of New Zealand.