香港社會醫學學院
HONG KONG COLLEGE OF COMMUNITY MEDICINE
founder College of the Hong Kong Academy of Medicine
Incorporated with limited liability

November 2006

Part II Fellowship Examination in Administrative Medicine

Case Study 4

You are the Chief Executive Officer of a teaching hospital well known for its excellence in gastroenterology. You receive a call from a consultant pathologist of your hospital in an agitated tone, telling you that a major patient incident has occurred in the hospital. When you learn about the details you recall that five weeks ago your Hospital Governing Board Chairman told you about his father's passing some blood in the bowel motions. You arranged an early appointment for his father to consult the Chief of Service of your Surgical Department, a renowned colorectal surgeon. Two weeks ago the surgeon told you that he would schedule a semi-urgent sigmoid colectomy for the patient because he found an ulcerated polyp in the sigmoid colon during colonoscopy, and biopsy of the polyp showed malignancy.

The pathologist tells you that the colectomy specimen of the Chairman's father does not show the expected cancer. After thorough review he finds out that there is a mix up of two colonic biopsy specimens due to incorrect labelling. The malignant specimen actually belongs to another patient undergoing colonoscopy on the same day while the specimen of the Chairman's father is actually free of malignant cells. The pathologist goes on to complain that when he told the Surgical Chief about this incident and asked him to inform the two patients, the surgeon bluntly refused to do so, saying that since biopsy reports were prepared by the pathologist, it should be the latter's responsibility to inform patients if anything went wrong about the report. The pathologist feels aggrieved he asks you to intervene, or he will disclose the case to the Board Chairman himself.

When you call the surgeon and ask him about the case, he remarks that he took up the case only as a personal favour for you, and the obvious queue-jumping consultation reflects this. He says he will see the other elderly patient as soon as possible to arrange for the appropriate surgical treatment, but he does not agree with you that he should tell the Chairman's father of the error. He adds that as far as the workflow of colonoscopy is concerned, he only performs the procedure, and the labeling and dispatch of specimens is left to his trainees. If this incident is put under the limelight, it will ruin the future career of the concerned trainee who happens to be the son of your intimate friend. He argues that since the Chairman's father has fully recovered and will not suffer any further harm for remaining ignorant of the incident, there is no reason to kick up a fuss. He also reminds you that the Board Chairman has recently indicated his intention to donate a significant sum to his department for upgrading the endoscopy room into a modern laparoscopic surgery suite. The disclosure of the incident may very likely jeopardize the donation.

What are the issues this case raises?
How are you going to manage the situation?

2006 Case Study 4 Key points

For Examiner

Pass candidate

Issues raised by this situation

- Risk management concerning patient safety and medical errors
- Correct identification of patients and specimens
- Open disclosure: indications, skills and culture building
- "No blame" or "just" culture for patient incidents: Systems approach Vs individual accountability approach
- Medico-legal issues
- Solicitation and acceptance of Donation by clinical departments

Management of the situation

- Damage control and management of the other patient with true malignancy
- Open disclosure to patient and relatives
- Communication with the Board Chairman
- Preparation for public affairs and media interest focusing on hospital reputation
- Legal advice seeking
- Root cause analysis and recommendation for preventive actions
- Management of staff involved in the case aiming at maintaining morale, encouraging incident reporting and sharing lessons learned

Outstanding Candidate

Further elaboration on:

- Clinical governance: definition, concept, change management, structure, processes and outcome monitoring
- Prospective risk scanning, risk assessment and risk register
- Sentinel event and incident reporting system
- Staff training and capacity building for clinical risk management
- Relationship with Governing Board members and ethical concerns