香港社會醫學學院
HONG KONG COLLEGE OF COMMUNITY MEDICINE
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# Part II Fellowship Examination in Administrative Medicine

## Supplementary Case Study

You are the chief executive of a major acute hospital. One day the hospital risk management officer informed you about a medical incident which is detailed as follows:

A 40-year-old man presented to the Department of Medicine with thrombocytopenia and bleeding tendency a year ago. He was treated as having haematological disorder without much improvement. One month ago he was admitted to the hospital with severe infection and the test for antibody against HIV (anti-HIV Ab) was positive. The test for HIV was performed in a separate Central Laboratory under the Regional Health Authority. The laboratory staff also informed the attending clinician that an anti-HIV Ab test had been performed for the same patient a year ago and the test result was positive at that time. The attending clinician, on going through the case record, confirmed that an anti-HIV Ab test was ordered by an house officer when the patient first presented to the hospital a year ago. Although the central laboratory staff said that the hard copy of the test result was sent back to the hospital, the report form could not be found in the case record nor was the consent form for the test. It was the routine practice for the Central Laboratory to mail the result directly to the doctors who ordered the tests. There was no mechanism to ensure that the result did reach the doctors.

The patient's clinical condition was severe. He was informed of the positive HIV test result and the prognosis by the clinician. The patient was married with 2 young children. He admitted that he had extramarital unsafe sex practice for two years. His wife did not know about the diagnosis. The information on the missing test result and delayed in diagnosis had not been disclosed to the patient yet.

a) Outline the key issues that you as hospital chief executive would need to consider in handling this incident.
b) Discuss your management plan of action to deal with the situation in
   i) the coming 1 week
   ii) the next 3 months

**2006 Supplementary Case Study Key Points**

**For Examiner**

A. Issues
   1. Risk management:
      a) Missing results (improper record keeping)
      b) Communication gap between laboratory and clinician
   2. Informed consent issue: patient's consent was not obtained for the first HIV test
   3. Open disclosure: the patient had the right to be informed about the incident
   4. Liability to the patient – delayed in diagnosis (and hence proper treatment) might adversely affect the prognosis
   5. Patient data confidentiality: the patient might not want his wife to know the diagnosis. However, the wife should be informed of the incident as she might have been infected with HIV through the husband
   6. Possible liability to the patient's wife: suppose the patient's wife eventually turned out to have HIV infection. It could be argued that if the diagnosis was made 1 year ago, the chance of infecting the wife could be minimized.

B. Plan of actions:

a) Initial response (hours $\rightarrow$ first few days)

- Organize meeting of crisis management team (CMT):

  HCE, designated hospital administrator (coordinator + record keeping)
  public relations officer
  +
  chief of service
  +
  risk management manager
  +
  ± external expert (responsible body of medical opinion, clinical microbiologist in this case)

- Ascertain facts, identify issues and stakeholders and determine the line to take, then touch base with
  i. corporate legal advisor
     - advice
     - insurance notification, permission of disclosure
     - agreed on the line to take
  ii. corporate public relations manager
     - advice
     - agreed on the line to take
  iii. inform chairman of the Hospital Governing Board
  iv. inform the head of the organization
- Disclosure to patient about the delayed in diagnosis
  - patients' treatment plan / prognosis
  - express apology
  - factual, non-defensive, showing general concern and indicate that the organization is taking prompt, appropriate action to incident & resolve the situation
  - endeavour to obtain consent from the patient to disclose the incident to his wife
  - attentive to psychological needs of the patient and the relatives
- Check anti-HIV Ab for patient's wife after open disclosure to her
- Disclosure to media (when enquired)

- prepare press release statement

b) Monitoring & resolution (within 1 week)
- Act quickly to investigate the event
- Have regular CMT meetings to update findings & ensure the appropriate actions. May use technique of Root cause analysis

  RM manager – management arm
  \+
  COS – clinical arm
  } may warrant to set up a separate Investigation Panel

- Final result
  - cleared by legal advisors / insurers
  - disclose to patient / relatives
  - facilitate negotiation via arbitrator / lawyer on compensation

c) Evaluation & follow-up (system improvement) (within 3 months)
- Lessons-learnt passed to hospital risk management committee – action plan laid down for improvement
- Improvement measures in
  - system, esp communication with the Central Laboratory
  - training & education on obtaining informed consent and the principle of open disclosure
  - notification
  - monitoring / audit
- Informed Hospital Governing Board and other relevant authority of the improvement measures
- Errors due to non-compliance to standard procedures – disciplinary action to concerned staff, if needed