香港社會醫學學院
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Administrative Medicine Part II Fellowship Examination 2014

Case Study 1 (Compulsory)

You are the Hospital Chief Executive (HCE) of a large regional hospital under the Hospital Authority.

You received a call from the Chief of Service (COS) of your hospital who appears rather distressed. He informs you that about 3 weeks ago his histology Laboratory received a specimen bottle containing four pieces of gastric biopsy specimens. The bottle was labelled with the personal particulars of a male patient. However, on the following day he received a call from a young gastrointestinal (GI) specialist informing him that there has been a mixing up of the gastric biopsy specimens of two consecutive patients (one male and one female) during his recent upper GI endoscopy session due to a mistake committed by the assisting nurse. The GI specialist requested the COS to try to differentiate the four specimens and provide the pathology reports accordingly. The COS informed the GI specialist that it was impossible to meet his request, and suggested that the GI specialist report the case through the hospital patient incident reporting system (AIRS). He also informed the GI specialist that there would be the need to repeat the endoscopy examination for the two patients and re-do the biopsies if pathology reports were considered essential for diagnosis. The GI specialist said he would consider that carefully. However, the COS noticed that there has been no further sending in of gastric biopsy specimens by the GI specialist since then.

Yesterday the GI specialist came to the COS's office and begged him to examine the specimens and provide pathology reports if all the specimens were normal. He admitted that he has not informed the two patients about the incident, and so no repeat of the endoscopies. There was urgency on this matter as one of the two patients will come back to hospital for follow up two days later. In response to such request the COS examined the

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specimens this morning but noticed that one specimen contains malignant looking cells suggestive of gastric carcinoma, while the other three specimens were normal.

In view of the seriousness of the matter, the COS calls you to seek your advice. He has passed the message to the GI specialist who appeared distressed and did not know what to do after knowing the result. When you check the AIRS reports made in the past three weeks you cannot find reporting of this incident. You call the Nurse Manager of the Endoscopy Suite for more details, and the latter informs you that she has been aware of the incident, and that the concerned nurse is a close girlfriend of the GI specialist. The GI specialist vowed to her that he would settle the case with the pathologist, and that the Nurse Manager should not report the case through AIRS.

What are the issues in this case and how do you manage this?

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Key Points

Three (3) core requirements for this question

1. Candidate should realise this is a serious clinical incident (is it a Serious Untoward Event or SUE?) and should demonstrate a systematic method of dealing with this.
2. Support for the patient(s) affected by this error, including the role of Open Disclosure.
3. Management of this incident.

Question writer's notes (these are not meant to be an exhaustive check-list but as prompts for Censors)

Investigation

Fact finding: Which part of the specimen collection process in the endoscopy suite is at fault?

Is there clear protocol for specimen collection and handling in the Endoscopy suite?

Is there existing protocol in other departments of the hospital handling pathology specimens such as the operating theatre?

Should this incident be labelled as "Serious Untoward Events (SUE)?

Should you report the incident to HA Head Office?

This incident requires a serious incident review panel using some form of root cause analysis process.

Need for disciplinary actions for the involved staff, the GI specialist, the assisting nurse, the Nurse Manager and the COS?

Management of patient

Open disclosure process. Candidate should be able to provide comprehensive description of the process

Need for urgent repeat of endoscopies and gastric biopsies. Any alternative means of avoiding such repeat, e.g. using chromosomal study to confirm the gender of the specimen containing malignant cells?

Support of the two patients regarding this incident

Need for medico-legal consultation by the involved staff and the hospital?

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General management of incident

Need for educating staff the purpose of reporting patient incidents through AIRS and the importance of timely reporting

The meaning of just culture for handling involved staff in medical incidents

How can similar incidents be prevented from happening in the future?