



**Office of the
Health Complaints Commissioner
2007**

0604016 Investigation into a complaint against BreastScreen Tasmania

s. 23 (1)(c) – a health service provider acted unreasonably in the manner of providing a health service – failure to comply with an undertaking to forward films to an interstate surgeon – communications – the exercise of discretion regarding the policy that results be provided to the client via a general practitioner. Report issued January 2007.

A medical practitioner lodged a complaint against BreastScreen Tasmania on three grounds: firstly that a policy which required that results are forwarded to the client's general practitioner was inflexible; secondly she was critical of the manner in which the then Clinical Coordinator of BreastScreen Tasmania communicated with her and with her nominated physician regarding the release of information to clients; and thirdly the complaint was made that BreastScreen Tasmania had failed to comply with an undertaking given to a surgeon to forward films prior to surgery.

The complainant self referred to BreastScreen Tasmania and was recalled for further testing when routine mammography detected an abnormality. On 4 November 2005, she attended this appointment. She was at that date living in Victoria, having moved to a rural area in October with her husband who was undertaking work as Medical Coordinator in a hospital. She flew from Victoria to Tasmania to attend this appointment and to attend to family matters over a period of 2 days. She was advised that she would need to return on 8 November for her pathology results but, as she would have returned to Victoria by then, she requested that the pathology results be sent directly to her. BreastScreen Tasmania was aware that she was a GP but were probably unaware that she had worked for about two years in Palliative Care Services.

The complainant was advised that the policy of BreastScreen Tasmania was that the results would be sent to her GP. Given her recent move interstate, the complainant was reluctant to nominate an unknown GP and sought an exception to the policy. This was refused. She then proposed her husband as the nominated medical practitioner, but BreastScreen Tasmania concluded that the protocol would be adhered to and re-iterated that she was to nominate an 'independent' GP. BreastScreen Tasmania indicated that the decision was made having regard to the potential long term psychological impact of a diagnosis of malignancy being communicated without adequate psycho-social support.

The conclusion reached was that BreastScreen Tasmania could have provided the complainant or her husband with her pathology results but that they made their decision in good faith and after careful consideration of their client's perceived interests. Given the complainant's experience and background and her clearly

expressed wish to receive the test results directly, it would not have been unreasonable for BreastScreen to depart from its policy in this case.

The complainant returned to Victoria and a Consultant Physician offered to receive her results from BreastScreen Tasmania. The then Clinical Coordinator contacted the physician by telephone and was critical that he was not an 'independent' GP and would not be providing the type of support and ongoing care BreastScreen Tasmania regarded as necessary. The complainant was aggrieved at the tenor of these communications and the then Clinical Coordinator apologised for those aspects of the conversation which were perceived by the physician as aggressive. It is clear that both believed that they were acting in the best interests of the complainant, in the Clinical Coordinator's case by insisting on a policy she and others believed would minimize the trauma associated with the communication of malignancy and in the physician's case in supporting what he clearly considered to be the complainant's right to access her biopsy results. In the circumstances no criticism was made of either practitioner.

The complainant anticipated malignancy and sought the results so she could arrange for treatment. Her grievance was exacerbated when BreastScreen Tasmania failed to forward the mammogram to her surgeon. BreastScreen Tasmania had no record of the call and initially denied that any contact had been made. The surgeon stated and her secretary confirmed that she had contacted BreastScreen Tasmania and that arrangements were made for the complainant's films to be forwarded. The phone records confirmed that two calls were to BreastScreen Tasmania. The films were not forwarded to the surgeon and it appears that the person who took the call did not have the authority to give that undertaking, did not record the contact details and did not advise the surgeon that the complainant's express consent would be required. It was concluded that the administrative arrangements within BreastScreen Tasmania for forwarding the films were, in this instance, unsatisfactory and a message record-keeping system was required. BreastScreen Tasmania has since implemented a system which electronically records and archives incoming phone messages.

The recommendations made were firstly that BreastScreen Tasmania provide a written apology to the complainant and her surgeon, for failing to forward the films to the surgeon as undertaken, and secondly that the report of this investigation be referred to the Cancer Screening and Control Services' Consumer Reference Group and Policy Review and Quality Management Committee for their information.