



Office of the  
Health Complaints Commissioner  
2007

**0506040 Investigation into the complaint against the North West Regional Hospital – a failure to admit and diagnose a seriously ill patient – Finalised March 2007**

**Section .23 (1)(c) of the *Health Complaints Act 1995* “a health service provider acted unreasonably in the manner of providing a health service” and s. 23 (1)(d): a health service provider failed to exercise due skill.**

A complaint was lodged by a woman on behalf of her deceased husband relating to his treatment at the North West Regional Hospital (NWRH). She complained about the lack of attention given to her late husband’s condition and lack of diagnosis. This involved 6 presentations to the Department of Emergency Medicine (DEM) within a relatively short time frame, 3 admissions to Surgical West and one admission to Spencer Clinic. She made specific complaints about the standard of the nursing care and the attitude of a treating medical officer who sought to discharge her husband from a surgical ward when she believed he required hospital care. Her husband was transferred to the Launceston General Hospital (LGH) and died a short time later of cholangiocarcinoma with an approximate interval of 3 months between onset and death.

This condition was not diagnosed by any of the medical practitioners at the NWRH, some of whom were specialists. This raises the question of whether this condition could reasonably have been diagnosed. An expert opinion was obtained and the opinion was that it is very difficult to provide an early diagnosis for cholangiocarcinoma. It is very rare and, based on epidemiology, only 4 patients a year would be diagnosed in Tasmania and the prognosis is generally poor.

However, the opinion was that the care and management of the complainant’s husband at some of the presentations at DEM was “*not up to an expected standard*” and his symptoms “*should have been reviewed by a more senior clinician from DEM or if unavailable an inpatient registrar / consultant*”. The Director of DEM concurs with this assessment and states that there were numerous “*red-flags*” in relation to this person including “*multiple presentations, elderly with abdominal pain, abnormal blood tests, and on warfarin*” .

The complainant’s husband had a past medical history of ulcerative colitis with a total colectomy and ileostomy, deep venous thrombosis due to a pulmonary embolism, depression and a cholecystectomy. She believed that the medical practitioners failed to investigate the physical symptoms her husband was experiencing because of his depression and to a degree this aspect of her complaint was substantiated.

The multiple presentations, the failure to refer to test results and the absence of adequate reviews or referrals brought into question of the level of experience of the medical practitioners in DEM and whether the arrangements for review by senior medical practitioners were operating effectively. The expert commissioned to assist the investigation identified the lack of review as a systems problem where the DEM is staffed with junior staff (interns and residents) or limited registration overseas graduates with limited senior supervision. The NWRH commented that it is difficult to attract specialists to regional and rural hospitals, such as the NWRH, and the expert commissioned commented that traditionally there is a reliance upon junior medical staff and overseas trained doctors to help provide patient care. Adequate supervision is critical and he suggested that there should be operational guidelines for referral to a more senior staff member, who can take responsibility so that *“Triage category 3, multi-system disorder, co-morbidities, should be seen by or the case presented to one of the rostered senior doctors or in their absence an inpatient team ...”*. A recommendation was made accordingly.

The complainant’s husband had a complex medical history and a number of medical conditions which would have caused him pain. He also suffered from anxiety and depression. Reference was made by the expert to his mental health co-morbidity and that it is well documented that less experienced doctors are sometime persuaded that this is responsible for serious symptoms. Such patients are not investigated as fully as patients without a mental health disorder.

The conclusion was that this patient’s mental disorder appears to have prevented the treating doctors from carrying out further diagnostic tests. The treating doctors failed to review the results of the tests and symptoms which were consistent with a serious illness and had little regard to his multiple presentations. His pathology was not adequately reviewed by his treating practitioners until his admission to the Spencer Clinic. The decision to transfer this patient to a tertiary institution for review took 5 days and was an unacceptable delay in the circumstances. There were deficits in his nursing care.

Ultimately the outcome would have not altered in that this patient would most likely have died from cholangiocarcinoma, a rare condition and a condition which in general would not be readily diagnosed. But the condition does cause quite serious symptoms, sufficient to warrant a referral to a specialist where the condition would usually be discovered. His co-morbidity and his mental state distracted some of his treating medical practitioners from a thorough examination of his psychological symptoms.

Recommendations were made to the NWRH on matters of policy and guidelines to address systemic issues to ensure that note is taken of pathology results and senior medical practitioners review cases particularly when there are multiple presentations and unscheduled revisits at the Department of Emergency Medicine.

The NWRH advised that they agreed with the recommendations and would implement or reinforce the policies or protocols suggested. The senior emergency department staff had discussed Recommendation 3 and agreed to institute a formal policy to provide that: *The NWRH develop operational guidelines for referral to a more senior staff member of all Category 3 (and above) patients to incorporate the following concept: “Triage category 3, multi-system disorder, co-morbidities, should be seen by or the case presented to one of the rostered senior doctors or in their absence an inpatient team”*.

