

Case Summary

Complaint against the Hospital Authority for lack of consideration towards the well-being of the patient, resulting in delay in giving suitable medical treatment

THE COMPLAINT

The complainant is dissatisfied with the Hospital Authority (HA)'s patient care provided to his son (patient) in the treatment of malaria. By way of background, patient fell ill soon after his return to Hong Kong in early February 1996 after visiting Myanmar for two weeks. On 11 February 1996, patient attended a government clinic on an outlying island and was referred to a HA hospital (Hospital A) where he was treated for an upper respiratory tract infection and was discharged.

2. On the evening of 13 February 1996, patient visited a private doctor and was offered three differential diagnoses, one of which was malaria. Patient was immediately referred to the same government clinic. Given his poor conditions, he was helicoptered to another HA hospital (Hospital B). On arrival, patient was seen by the duty doctor at the Accident and Emergency Department at 9:07 p.m. As clinical findings were compatible with malaria infection, patient was admitted to the medical ward for further management. On admission, blood tests were taken and treatment was given by way of antibiotics for septicemia, but no malaria treatment was given. On the morning of 14 February 1996, although test results for malaria were not yet available, patient was transferred to another HA hospital (Hospital C) which had a specialist Infection Diseases Unit because patient's liver and renal functions were deranged. On arrival at

Hospital C, blood tests were again taken from patient. Patient was given treatment for malaria on the morning of 15 February 1996 when tests results confirmed patient suffered the most virulent form of malaria. Patient died on 16 February 1996 and the medical cause of his death was pernicious malaria.

3. Following initial enquiry with the HA, this Office decided that an investigation should be conducted to see whether there was any lack of consideration on the part of HA' s staff towards the well-being of the patient and whether this had resulted in delay in giving him suitable medical treatment as alleged by complainant.

FINDINGS AND CONCLUSION

4. In the present case, this Office finds that malaria treatment on patient only began some 36 hours after detection of clinical findings compatible with malaria infection was due to a combination of the following

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- (i) The normal operating hours of the hospital laboratory at the time were 9.00 a.m. to 5.00 p.m. on weekdays and 9.00 a.m. to 1.00 p.m. on Saturdays. Hence, tests of patient' s blood samples taken after 9.00 p.m. on 13 February 1996 at Hospital B on admission were carried out at least some 12 hours later on the next morning.
- (ii) Although the first and subsequent reports on the results of malaria tests confirming malaria infection at Hospital B were available by 3:45 p.m. on 14 February 1996, the results were never passed to Hospital C where patient was transferred to that morning.

- (iii) At Hospital C, blood tests were also conducted for patient on admission. The blood test results confirming malaria infection were available at 4.28 p.m. on 14 February 1996 and transmitted via the computer network to the ward, but the attending doctor only noted the print-out blood test results of patient at 9.19 a.m. on the next morning because the results missed the afternoon round of automatic batch print-out of laboratory results scheduled twice daily at 9.00 a.m. and 3.30 p.m. Thus, at least another crucial 17 hours were lost despite the very purpose of setting up a computer network was to enable efficient reporting of laboratory results to the ward.

5. At the time of the incident, there were no guidelines on the transfer of laboratory test results across hospital clusters. In this case, the referral memo from Hospital B to Hospital C documented the result of a Complete Blood Picture (CBP) Examination was pending and there was no mention of blood test for malarial parasites although this was being carried out.

6. The HA admitted the main problems revealed in this case were the lack of a high index of clinical suspicions on malaria infestations. Arising from this incident, an Expert Internal Enquiry was commissioned and the following improvement/remedial measures were adopted-

- (i) In June 1996, guidelines on handling of malaria cases were formulated and updated in January 1997 to remind doctors to raise their awareness about malaria, particularly for patients with recent travels to endemic areas. Clinical staff were also advised to respond

proactively to patients with symptoms of suspected rare infectious diseases. The guidelines were updated in January 1997 to alert staff for urgent communication of essential medical information.

- (ii) In September 1996, guidelines on the handling of patients suspected of malaria infection were promulgated with emphasis on speedy arrangement of blood tests and reporting on the test results. A 24-hour laboratory service was also established in September 1996 to improve the provision of emergency blood test service for the whole territory.

- (iii) Commencement of a thorough review on inter-and intra-hospital communication of essential medical information.

7. On the basis of the above findings, this Office has the following views -

- (a) This is a sad incident but it is not for this Office to determine if the 36 hours taken before the commencement of malaria treatment on patient was attributable to his death or whether the outcome might have been different if malaria treatment began earlier.

- (b) It was indeed unfortunate that at the time no blood testing for malaria was available outside normal hospital laboratories working hours and the request for blood test was not requested on an urgent basis. This Office is pleased that the HA has implemented remedial measures and made available

emergency blood test service round the clock since September 1996.

- (c) Given malaria infection can be fatal and as the progression of the disease can be rapid, time is of the essence in malaria treatment. As such, this Office finds the following situations unacceptable -
- (i) It would not be unreasonable to expect medical professionals to have adopted a more responsible and caring attitude given malaria could be fatal despite the fact that patient had already been transferred to another hospital. In the present case, however, the attending doctor at Hospital B did not bother to immediately inform the blood tests result by telephone or fax to counterparts at Hospital C who were attending to patient by assuming that they should know.
 - (ii) Furthermore, the medical professionals of Hospital C also did not ask the referring doctor at Hospital B to keep them posted of the CBP Examination result or check with the doctor despite the referral memo stated that the CBP Examination result was pending.
 - (iii) At Hospital C it was apparent that the reporting of test results through the computer network had systemic flaw and procedural deficiency, as it still took 17 hours for the attending doctor to be aware of the test results and hence a further delay in commencing malaria treatment on patient.

8. This Office considers that the lack of communication and guidelines on transfer of laboratory test results across hospital clusters highly unsatisfactory and this situation has left the essential communication of medical information to the discretion of the medical professionals. In the present case, there was a lack of consideration towards the well-being of patient by the attending doctors, resulting in a delay in providing malaria treatment of patient. All points considered, The Ombudsman concludes that this complaint is partially substantiated.

RECOMMENDATIONS

9. The Ombudsman remains very concerned about the lack of guidelines on transfer of laboratory tests results and vital medical information across hospitals on transfer of patient as well as the less than adequate and timely inter- and intra-hospital communication as time is of the essence in patient care. The Ombudsman therefore recommends the CE of the HA to -

- (a) urgently put in place guidelines on transfer of essential medical information upon transfer of patients between hospitals including information and laboratory test results which become available after the transfer is effected; and
- (b) urgently review the adequacy of the scheduling of the automatic batch print-out of laboratory results twice a day and the procedures and monitoring mechanisms of the computer network transmission to the ward to ensure that cases requiring urgent attention must not be missed.

RESPONSE FROM HA

10. The CE of HA reiterated that the hospitals had all along been rendering care and treatment for the patient and that the delay in treatment was due to the lack of a high index of awareness of malaria rather than system fault or procedural deficiency. He also contested the investigative powers of The Ombudsman in this case with reference to a court case in which it was ruled that the exercise of clinical judgement by medical practitioners is outside the investigation powers of The Ombudsman. He considered the delay in providing anti-malarial treatment for the patient to be an action involving clinical judgement but not an administrative act.

FINAL REMARKS

11. The Ombudsman is of the view that many actions and decisions of medical professionals involve professional skills, judgement and experience. However, it would be inappropriate to classify all actions (or inaction) and decisions taken by a doctor towards a patient as clinical judgement or decisions as demonstrated in this case. The present complaint is one on "lack of consideration" on the part of the medical professionals towards the well-being of the patient resulting in "a delay" in instituting malaria treatment. Under The Ombudsman Ordinance, both "lack of consideration for a person affected by any action (or inaction)" and "delay" constitute acts of maladministration and are investigable by The Ombudsman.

12. The delay as revealed in the investigation was avoidable had the referral doctor concerned at Hospital B immediately relayed the laboratory blood test result upon its availability to the attending doctor at Hospital C having regard to the well-being of the patient and had the attending doctor

at Hospital C kept a close watch of the laboratory test results so that malaria treatment could have begun many hours earlier.

13. All points considered, The Ombudsman is of the view that there are no justifiable grounds to change the findings and conclusion of this report.

14. Finally, on the court judgement regarding The Ombudsman's investigative powers relating to the exercise of clinical judgement, this Office does not wish to comment on the judgement as the appeal period is not yet over.

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