Patient Ombudsman
Ombudsman des patients

Investigation completed: December 2024

Investigation Summary

Failure to Communicate and Act on a Cancer Diagnosis

This investigation summary allows Patient Ombudsman to publicly share the outcome of a formal investigation to raise awareness of important issues and specific circumstances negatively impacting health care experiences in Ontario. More importantly, the resulting recommendations are intended to be a catalyst for systemic change and improvement.

Patient Ombudsman has decided not to share identifying information so that the focus remains on the complaint, the issues, and the resulting recommendations. Only those individuals and organizations directly involved with the investigation were provided with the full investigation report. Patient Ombudsman continues to follow-up with the health sector organization on its efforts to implement these recommendations.

Complaint

On October 12, 2022, Patient Ombudsman received a complaint from a patient's family doctor and the patient's substitute decision maker (SDM) detailing a failure to communicate and act on a cancer diagnosis.

In August 2021, the patient was admitted to the hospital for orthopedic surgery through the emergency department subsequent to a fall that led to a fracture. Tests that were ordered at the time the patient was undergoing surgery indicated that the underlying cause of the fracture was cancer. The cancer diagnosis was not communicated to the patient, or their family and no treatment was undertaken until a new family doctor identified the report in August 2022 and notified the patient's SDM and the hospital.

The family doctor and the SDM complained to Patient Ombudsman because the hospital did not apologize for what happened, particularly given the patient's cancer had gone untreated for a year and metastasized to the patient's bones, which caused unrelenting pain. The SDM was concerned that they had waited a substantial amount of time for a written summary of the hospital's investigation and quality review. A letter was provided to the SDM six months following the SDM's complaint to the patient relations department, and it did not explain how the result was missed or what the hospital would do to prevent such a thing from happening again. Furthermore, the hospital did not acknowledge the impact of this error on the patient or apologize to the patient for what happened.

Investigation

Patient Ombudsman conducted interviews with the patient, the SDM, the family doctor, hospital medical staff, including surgeons, radiologists, pathologists, oncologists, patient relations staff, patient relations leadership, quality and patient safety leadership, management, and hospital investigator as

well as the leadership and managers responsible for the hospital's recently implemented electronic health record.

Patient Ombudsman reviewed several thousand documents including the patient's medical record, email exchanges between the hospital and complainant, correspondence from the patient's family doctor as well as the documentation in our early resolution file. We reviewed hospital policies and procedures pertaining to patient relations, quality reviews, just culture and disclosure processes as well as the incident report and causal diagram the hospital produced following its internal review process. We reviewed scholarly articles from medical and health quality journals on the following subject matter: clinical test result management, the impact of electronic health records on clinical practice, disclosure processes when patient safety incidents happen, and principles of just culture.

Recommendations

Critical pathology reports not communicated

1. Patient Ombudsman recommends that the hospital conduct an audit or review of pathology reports to ensure that other patients have not experienced a similar oversight.

2. Patient Ombudsman recommends that the hospital provide some additional coaching to the orthopedic surgeons and reporting pathologists to ensure that the orthopedic surgeons and reporting pathologists accurately understand which types of results will be reported with a phone call/email pursuant to the hospital's policies.

Physician concerns with system and process for receiving pathology results

3. Patient Ombudsman recommends that the hospital conduct an assessment and engage with their physicians to see what more can be done to reduce physician administrative burden.

4. Patient Ombudsman recommends that the hospital implement a coding or flagging system in the electronic health record that permits pathology to identify abnormal and critical results, even if they are not "unexpected."

5. Patient Ombudsman recommends that the hospital take measures to ensure that rotating most-responsible physicians receive and are able to act on pathology reports.

Adequacy of the investigation, quality review, and Safety Learning System report

6. Patient Ombudsman recommends that the hospital update its quality review process to ensure that:

    - reviews are conducted on the basis of all relevant facts of a case, including seeking out relevant information about a patient's current medical condition and the impact of a patient safety incident on their health/quality of life;
    - all clinicians involved in the patient's care should be consulted; and
    - reviews should consider potential systemic factors, including those Patient Ombudsman identified in this case.

7. Patient Ombudsman recommends that the hospital take steps to ensure that the documentation in Safety Learning System reports is as comprehensive and accurate as possible to ensure learning occurs from this process.

8. Patient Ombudsman recommends that the hospital amend its policy related to quality reviews and the policy concerned with disclosure to ensure that after every patient safety event causing harm: the material facts, identified cause(s) of a patient safety incident, the systemic steps taken following a patient safety/quality review, are fully disclosed to the involved patient/their SDM. Also, any clinician whose actions or omissions are found to have contributed to the incident should be informed of this fact regardless of whether there is any need for disciplinary action and they should be provided with the opportunity to respond.

9. Patient Ombudsman recommends that the hospital develop a standard information sheet/script for patients and caregivers that outlines the hospital's typical process and the potential outcomes for a patient safety investigation and quality review. This document should provide sufficient information so that patients and caregivers can understand the process, timeframe, what is expected of them and what kind of information they will receive at the conclusion of the process.

Patient relations department transparency

10. Patient Ombudsman recommends that the Patient Relations Department develop communication materials that transparently introduces the Patient Relations Department, and the role of a patient relations specialist, including their risk management responsibilities. The communication tools should provide an explanation of how they balance their accountabilities for patient relations and risk fairly (or how these two functions of their role are complementary) and what a patient/SDM can expect from the internal complaints process.

Cette resource est également disponible en français.