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Health Insights

Missing faxed scan result triggers the Coroners Court to call for robust standards regarding the communication of radiology results

The Coroners Court of Victoria has called for the development of a set of standards specifically setting out systems for the communication of imaging results, and defining the roles and responsibilities of diagnostician and referring doctors with respect to the same. The recommendations were made following an inquest into the death of Mr Mettaloka Halwala, who passed away alone in his hotel room in November 2015 due to complications arising from chemotherapy treatment.

By Kellie Dell'Oro, Principal
E +61 3 9810 6775
T kdelloro@meridianlawyers.com.au

By Anna Martin, Associate
E amartin@meridianlawyers.com.au

Circumstances surrounding Mr Halwala's death

At the time of his death, Mr Mettaloka had been undergoing chemotherapy treatment for Hodgkin's lymphoma. Although he was located in the Goulburn Valley region, he was under the care of a consultant haematologist (**Dr F**) at St Vincent's Hospital in Melbourne, who provided an outreach service to the Goulburn Valley Hospital (**GVH**). Mr Halwala had received three chemotherapy treatments at GVH when he came under the care of Dr F who referred him for a PET scan at the Austin hospital on 27 October 2015.

The reason for the referral was indicated on the referral form itself as being "Hodgkin's Lymphoma Reassess after 2 cycles ABVD Chemotherapy". The referral requested that the PET Scan be booked for "10 or 11 November", and provided Dr F's contact details including fax number.

Mr Halwala received his third chemotherapy treatment on 30 October 2015, and the PET scan took place on 11 November 2015. During the procedure, Mr Halwala did not demonstrate any sign of a respiratory or other infection.

The PET Report was signed off by a nuclear medicine physician (**Associate Prof. L**), and stated that while Mr Halwala demonstrated an excellent response to treatment, the scan revealed findings consistent with lung toxicity resulting from the chemotherapy or an opportunistic infection. Unfortunately, it was inexplicably faxed to a different number than that indicated on the referral, and Dr F did not receive the PET Report before Mr Halwala attended GVH to receive his next chemotherapy treatment on 13 November 2015. Associate Prof. L did not call or contact Dr F directly, to report the results and the PET Report was not copied to any other recipients.

The day after treatment, Mr Halwala saw his family who described him as very sick and that he could "*hardly breath[e]*". On 16 November 2015, he called Dr F's rooms to report that he was unwell. The message from Dr F (relayed via his secretary) was that he should attend hospital if he felt unwell. Later that same day, Dr F opened his postal service mail and read Mr Halwala's PET Report. In knowing that his secretary had already advised Mr Halwala to go to hospital if he felt unwell he did not take any further steps to contact Mr Halwala that day, and planned to contact the oncology staff at GVH the following day. Before he could do so on 17 November 2015, Dr F received a phone call from police advising him that Mr Halwala had been found deceased in his hotel room.

Findings at inquest

Coroner Carlin's findings focussed predominately on the critical failure by the medical professionals involved in this case to ensure that the PET scan result was communicated to Dr F in a timely manner, noting that "*he may have survived if the results…had been conveyed to his treating doctor who had ordered the scan*".

The Coroner considered that the circumstances of the death revealed a "*significant disconnect between the expectations of the doctor who performed the scan and the treating doctor in relation to the communication of those results"*. Associate Prof. L assumed that Dr F would see her report before administering more chemotherapy, and would use the results to determine Mr Halwala's future management. She assumed that if the result had not been received in time, he would contact the Austin to obtain a copy. Equally, Dr F assumed that if the PET scan revealed an unexpected result, that he would be contacted.

This "schism in expectations" as the Coroner referred to it, is not limited to the personalities involved in Mr Halwala's care. She considered that the systemic nature of the problem was demonstrated quite simply by the fact that an expert conclave of medical professions called to the inquest "*were not able to agree as to what constituted a reasonable means of communication*". Such divergence indicated a clear need for robust Standards regarding the communication of radiological examination results and if there was any further need for convincing, Her Honour highlighted that as at 2012, communication failures in this area accounted for the second most common cause of malpractice litigation in the United States[1].

At the time of Mr Halwala's death, the only relevant guidelines at Austin Health were limited to the communication of a 'critical result', being that which *'…in its own right, represents a clear and immediate threat to the patient's life or limb'* and *'require[s] urgent clinical intervention'*. Such results were required to be communicated promptly and verbally by the diagnostic service to the responsible doctor.

In terms of any national standards, the Coroner referred to the Royal Australian and New Zealand College of Radiology (**RANZCR)** 'Standards of Practice for diagnostic and Interventional Radiology' which simply state that

[1] Sourced from the *Background* to the United Kingdom's Royal College of Radiologists (**RCR**) 2012 '*Standards for the communication of critical, urgent and unexpected significant radiological findings*'

nuclear medicine reports are generally provided to the referring practitioners within 24 hours of the examination.

The Australian Association of Nuclear Medicine Specialists (**AANMS**) 'Standards for Accreditation of Nuclear Medicine Practices' go a little further, specifying:

> *The timeliness of reporting will vary with the nature and urgency of the clinical problem. In general, the report should be sent to the referring practitioner within 24 hours of completion of the study. If there are urgent or unexpected findings, the specialist should use reasonable endeavours to communicate directly to the referrer or an appropriate representative who will be providing clinical follow-up.*

The terms "urgent" and "unexpected" as they appear in that paragraph are undefined, although we note that the Coroner considered that the term 'unexpected' can derive its meaning from the definition set out in 2012 UK Royal College of Radiologists (**RCR**) 'Standards for the communication of critical, urgent and unexpected significant radiological findings' as being "*cases where the reporting radiologist has concerns that the findings are significant for the patient and may be unexpected by the referrer."*

The Coroner drew stark comparison between the Standards presently available in Australia, and the Standards set by the UK RCR, which are more specific and categorise radiological findings into three, defined subsets being 'Critical findings', 'Urgent findings' and 'Significant unexpected findings'. The required method of communication for each subset is particularised and the Standards provide for fail-safe communication mechanisms in the case of certain categories of radiological findings. Further, the UK RCR Standards emphasise that the referring doctor, the radiologist and the healthcare institution are to each share responsibility for timely communication of results.

Her Honour expressed surprise at the absence of more comprehensive Standards in Australia, both at the associational and institutional levels and stressed the need for such guidance. She took the opportunity to emphasise the point that although *"appropriate care is not established simply by proof of compliance with applicable Standards and Guidelines…[they] should be regarded as laying down a minimum level of conduct."* In formulating any such standards, Her Honour made the comment that words like "timely", "urgent", "significant" and "unexpected" are unhelpful without explicit definitions.

The Coroner also heavily criticised the use of facsimile for the transmission of results, labelling it "*antiquated and unreliable*". Instead, she favoured electronic distribution as a fail-safe communication mechanism (as advocated by both the 2012 and 2016 UK RCR Standards), which she said should be "*used routinely and in addition to any more direct method*" (noting that it will never be a substitute for direct communication in appropriate cases). Her Honour also advocated the need to copy results to the patient's GP and, in cases where treatment is occurring at a different institution from the specialist, that institution.

We note that the possibility of providing results directly to the patients was raised as a potential fail-safe solution, however the expert conclave unanimously agreed that they did not consider results should be routinely provided to patients without an *"interpretive filter"* provided by the doctor.

Recommendations

The Coroner's final, articulated recommendations were that:

- the Royal Australian and New Zealand College of Radiologists, the Australian Association of Nuclear Medicine Specialists and the Royal Australasian College of Physicians collaborate to develop a set of Standards dedicated to systems for the communication of imaging results. The Standards should be as explicit as possible in setting out the roles and responsibilities of diagnostician and referring doctor and the required manner of communication in different situations consistent the conclusions and comments in this case, and
- Austin Hospital revise its current 'Oncology Referral Form for PET Scan' to include all information that may be relevant to the nuclear medicine physician performing the scan in determining the timeliness and manner of communication of the results; and
- Austin Hospital phase out fax transmission of imaging results as a matter of priority.

THIS ARTICLE WAS WRITTEN BY PRINCIPAL KELLIE DELL'ORO AND ASSOCIATE ANNA MARTIN. PLEASE CONTACT US IF YOU HAVE ANY QUESTIONS OR IF YOU WOULD LIKE FURTHER INFORMATION.