Management of bladder cancer
(04HDC11624, 4 April 2006)

Urologist ~ Genitourinary surgeon ~ District health board ~ Bladder cancer ~ Cystectomy ~ Consultation with colleagues ~ Decision-making ~ Patient safety ~ Employment issues ~ Standard of care ~ Professional standards ~ Rights 4(1), 4(2), 4(4), 4(5)

A woman was referred to a urologist by her GP for assessment of longstanding urinary tract problems. The urologist, a genitourinary surgeon, performed a cystoscopy and biopsy of bladder tissue. The biopsy revealed that the woman had squamous cell carcinoma of the bladder. Nine weeks later he performed a sub-total cystectomy and hysterectomy, and the woman was referred to a radiation oncologist for follow-up radiotherapy treatment. Four months later when she developed abdominal discomfort, the radiation oncologist performed a CT scan. The scan revealed a collection of fluid in the lower abdomen. He referred the woman to the urologist for review. The urologist performed a further cystoscopy and found that she had developed a fistula between the bladder and the mons pubis, which was thought to be related to a recurrence of her cancer. She died a few months later.

It was held that the urologist failed to biopsy the woman's fistula and to communicate his findings to the other doctors involved in managing her care, which had an impact on the planning of subsequent management options. His decision to perform a partial cystectomy in these circumstances was a severe departure from the expected standard of care, and he was found to have breached Rights 4(1) and 4(4). It was also held that his failure to consult his colleagues was not consistent with sound clinical decision-making and good quality care. In these circumstances the urologist breached Rights 4(2) and 4(5). Behavioural concerns, no less that clinical competence concerns, can place patients at risk and must be addressed by an employing district health board. However, the board was not held vicariously liable for the deficiencies in the urologist's clinical decision-making.

The Commissioner recommended that the Medical Council of New Zealand review the urologist's competence. The urologist was referred to the Director of Proceedings.

The Health Practitioners Disciplinary Tribunal upheld one charge of professional misconduct against the urologist. It concluded that the expert evidence showed that the failure to perform a total cystectomy constituted conduct that fell far short of that to be expected of a reasonably competent urologist, and that it amounted to malpractice (neglect of a professional duty) and negligence (a breach of duty in a professional setting). The Tribunal considered that a finding of professional misconduct was needed to protect the public, maintain professional standards, and punish the practitioner.

The urologist was censured, fined $5,000, and ordered to pay 30% of the costs of the investigation and prosecution. He was also ordered to practise under conditions. Interim name suppression was lifted.

Link to Health Practitioners Disciplinary Tribunal decision:
http://www.hpdt.org.nz/portals/0/med0639dfindings.pdf