Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

GPs breach Code for delayed diagnosis of woman's oesophageal cancer

20HDC02065

A doctor at a medical centre breached the Code of Health & Disability Services Consumers' Rights (the Code) for the delayed diagnosis of a woman's metastatic oesophageal cancer.

The woman, in her sixties at the time, attended consultations with two different doctors at the medical centre in the same month, with symptoms including fatigue, loss of appetite, seven kilogram weight loss over the previous two months and feeling cold.

The first doctor the woman saw (a part time locum) requested blood tests for a general initial investigation. The doctor said she made a request to the public hospital for an ultrasound scan of the woman's liver.

A letter was sent to the same doctor by the radiology department advising the woman had been prioritised as "category C", which indicated a waiting time for an ultrasound of 30–38 weeks. The letter advised the doctor to review the prioritisation to ensure it was clinically appropriate. However, the letter was sent to another practice at which the doctor worked and then it was posted to the correct medical centre. However the doctor does not remember ever seeing it.

When the woman visited the medical centre for a second time in the same month, with deteriorating symptoms, she saw a different doctor. The second doctor did not perform a physical examination or record any vital signs. He prescribed levothyroxine (for thyroid hormone deficiency) and omeprazole (for indigestion) and planned to review the woman again in four to six weeks' time and repeat blood tests.

The second doctor told HDC he recalls advising the woman that she should be admitted to hospital that day, but the woman refused because it was a public holiday. The woman's husband, who attended the appointments, does not recall this advice.

Five days later, the woman presented to the emergency department at the public hospital as her condition worsened and she was no longer able to swallow liquids. She was diagnosed with metastatic oesophageal cancer. Sadly, she passed away a few weeks later.

The Aged Care Commissioner, Carolyn Cooper, found the care provided by the second doctor fell below appropriate standards, namely his decision not to examine the woman, and the appropriateness of his management decisions. She found him in

breach of Right 4(1) of the Code which gives consumers the right to have services provided with reasonable care and skill.

Ms Cooper recommended the second doctor provide the family with an apology for the failings identified in the report and review the Community HealthPathways guidance on "Dysphagia and Dyspepsia and Heartburn/ GORD".

She also recommended the current owner of the medical centre consider the implementation of a new management process for filing of documents and consider implementing a new system for the appropriate management of locums, to ensure continuity of care.

Ms Cooper noted that the first doctor's documentation was incomplete in places and that the medical centre lacked policies regarding the management of outstanding results and tasks of short-term locum doctors.

25 September 2023

ENDS

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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