Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Southern District Health Board breached the Code over delayed colonoscopy

20HDC02382

A report released today by Health and Disability Commissioner Morag McDowell found Southern District Health Board (SDHB) (now Te Whatu Ora Southern) breached the Code of Health and Disability Services Consumers' Rights (the Code) over a delayed colonoscopy for a man with colon cancer.

The man, who had a family history of colon cancer, had four admissions to Dunedin Hospital between April 2018 and October 2019. On the second admission, he was scheduled for an outpatient colonoscopy in just over 12 weeks. The colonoscopy, and subsequent biopsy, revealed colon cancer.

The man's symptoms and history fulfilled the SDHB criteria and Manatū Hauora/Ministry of Health (MOH) referral guidelines for an urgent colonoscopy (within two weeks). A possible reason for the lower urgency was due to reliance on a normal result from a previous colonography (CTC). In light of this, the Commissioner's independent surgical advisor commented that the request could have been prioritised under a six-week timeframe.

In any event, Ms McDowell noted that, "the 12 week wait exceeded SDHB's own recommended timeframe and the MoH's guidelines by at least six weeks."

Accordingly, she found SDHB breached Right 4(1) of the Code which gives consumers the right to services provided with reasonable care and skill.

In the report, Ms McDowell, acknowledged, "the pressures faced by colonoscopy services at a national level, due to an increase in demand, paired with workforce shortages and recruitment challenges."

"However, it is my view that when investigations are clinically indicated as urgent, or semi-urgent, healthcare consumers have the right to expect them to be scheduled sooner than occurred in this case.

"A timely diagnosis can be particularly important for reducing morbidity and mortality for cancer patients, and often it is a key factor in survivability. Long waits for diagnostic procedures can also have a significant psychological impact on patients and their whānau who may be concerned that they have cancer," she said.

No breaches of the Code in relation to other aspects of the man's care were identified. However, Ms McDowell made an adverse comment about the concurrent

use of anticoagulant medication and the lack of clarity in the discharge advice about anticoagulation.

Ms McDowell noted that the report should be viewed in the context of SDHB's previous actions to address issues relating to restricted access to colonoscopy services, including commissioned external reviews.

"On assessment of the information provided to me, I am satisfied that Te Whatu Ora Southern has shown a commitment to implementing the recommendations of the reviews and many of the issues identified have been addressed," Ms McDowell said.

"I will continue to take a close interest in the quality of this service and maintain a watching brief over the pattern of complaints in this area."

Ms McDowell recommended that Te Whatu Ora Southern:

- Provide the man and his family with a written apology for the deficiency in the care provided.
- Consider a standardised checklist and format for the provision of anticoagulation advice on discharge, to ensure that all relevant aspects of advice are covered and presented in a manner that can be readily understood by the patient.
- Provide HDC with an update on current wait times for colonoscopy services, including any actions being taken to address delays where wait times are outside expected timeframes.

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Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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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