Breast cancer patient not informed of test result (12HDC00413, 30 May 2014)

Radiation oncologist ~ Breast surgeon ~ Breast clinic ~ Public hospital ~ Breast cancer ~ Test results ~ HER2 ~ Adjuvant therapy ~ Information provided ~ Patient management system ~ Right 6(1)

A woman had a mastectomy performed by a breast surgeon at a private breast clinic. Following the mastectomy, the surgeon sent the resected tissue for histology, which involved a range of routine tests including determining the HER2 receptor status. A positive HER2 status indicates a type of cancer that tends to be more fast-growing and may respond to Herceptin, a treatment that targets HER2 positive cancers and that is given only in conjunction with chemotherapy.

Post surgery the woman met with a radiation oncologist to discuss adjuvant therapy options. At that time, the HER2 result was unavailable. The radiation oncologist advised the woman that she had a very good prognosis and recommended radiation therapy. He did not recommend chemotherapy. There is no record that the pending HER2 result was discussed at this consultation.

A week later the woman's HER2 result became available, and it was positive. Despite being aware of the positive result, neither the breast surgeon (who saw the woman on a number of subsequent occasions) or the radiation oncologist informed the woman of the positive HER2 result.

The woman's radiation oncology care was transferred to a public hospital, where she underwent radiation therapy. The HER2 result incorrectly appeared as negative on a series of seven hospital clinic notes.

The woman later developed back pain and subsequently underwent a bone scan and was diagnosed with metastatic disease at the public hospital. The hospital medical oncologist obtained the woman's positive HER2 test result and informed her of the positive result for the first time.. The woman subsequently passed away from the metastatic disease.

It was held that the radiation oncologist failed to provide the woman with all the information she would reasonably expect to receive, including full information relating to her prognosis and her positive HER2 result. He also should have offered a referral to a medical oncologist. In not doing so, the radiation oncologist breached Right 6(1).

It was held that the breast surgeon's surgical care was adequate, however, adverse comment was made that it would have been prudent for him to have checked with the woman that she had received the HER2 result and that it had been discussed with her.

Adverse comment was made about the private breast clinic's patient management systems, and the importance of robust systems in the context of multidisciplinary care was emphasised. Adverse comment was also made about the public hospital's system for managing patient records.