Te Whatu Ora|Health New Zealand Waitaha Canterbury

General Medicine Physician, Dr B

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC00132)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. A man presented to an emergency department several times and was diagnosed with angina. A chest X-ray taken during one of the admissions identified a mass on his right lung, and a CT scan was recommended. However, the recommendation was not acted on, and the mass was not identified as malignant lung cancer until more than a month later.

2. This report examines the care provided to the man by the general medicine physician responsible for the man's care during the admission in which the chest X-ray was taken, and the care provided by Te Whatu Ora Waitaha Canterbury during the man's admissions to the Emergency Department in the second half of 2019. In particular, the report considers the responsibilities of clinicians who order imaging, and the importance of open disclosure when harm is discovered.

Findings

3. The Deputy Commissioner found that the physician's failure to act on the radiologist's report of the chest X-ray delayed the diagnosis of lung cancer for approximately four weeks. Although an earlier diagnosis may not have affected the outcome, the Deputy Commissioner considered that this was a serious departure from the standard of care and found the physician in breach of Right 4(1) of the Code.

4. The Deputy Commissioner noted that despite several different clinicians in two different departments being aware of the failure to action the radiologist's report, no clinician took responsibility for ensuring that the man was informed of this at the earliest opportunity. The Deputy Commissioner considered that this failure was attributable to systemic issues at Te Whatu Ora and constituted a failure to ensure that the man had all the information that a reasonable consumer in his circumstances would expect to receive. Te Whatu Ora Waitaha Canterbury was found in breach of Right 6(1) of the Code.

Recommendations

5. The Deputy Commissioner recommended that the physician apologise to the family and arrange an audit of radiology reports he had acknowledged having received.

6. The Deputy Commissioner recommended that Te Whatu Ora apologise to the family; update HDC on a planned review of its open disclosure policy and its plan to include patient referrals (including referrals that are to be actioned after discharge) to other services on Health Connect South; audit compliance with its policies regarding discharge summaries and open disclosure; consider whether the policy on discharge summaries should be updated to include a requirement that discharge summaries note any results that are still awaiting reporting; and update HDC on its plan to introduce a formal policy on the acknowledgement of electronic results.

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Complaint and investigation

7. On 28 January 2020, the Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Te Whatu Ora|Health New Zealand Waitaha Canterbury (Te Whatu Ora).[1] The following issues were identified for investigation:

- *Whether Canterbury District Health Board provided Mr A with an appropriate standard of care in 2019.*
- *Whether Dr B provided Mr A with an appropriate standard of care in 2019.*

8. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Mr A (dec)	Consumer/complainant
Mrs A	Wife of consumer/complainant
Te Whatu Ora Waitaha Canterbury	Provider
Dr B	Provider

10. Further information was received from the radiology service, Te Whatu Ora Chief of Radiology Dr C, respiratory registrar Dr D, radiologist Dr E, Te Whatu Ora Clinical Director for General Medicine Dr F, and senior medical officer (SMO) Dr G.

11. Radiologists Dr H, Dr I, Dr J, Dr K and Dr L, and registrar Dr M are also mentioned in this report.

12. Independent advice was obtained from a medical oncologist, Dr Orlaith Heron (Appendix A).

Information gathered during investigation

Background

13. Mr A was aged in his eighties at the time of events. He had a complex medical history, which included diabetes, heart disease, high blood pressure, and elevated cholesterol.

14. Through early to mid-2019, Mr A had suffered episodes of chest pain and, prior to August 2019, had presented to the Emergency Department (ED) at a public hospital several times. In the ED, the symptoms were attributed to Mr A's heart problems and diagnosed as angina.[2]

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to Canterbury DHB now refer to Te Whatu Ora Waitaha Canterbury.

[2] A type of chest pain caused by reduced blood flow to the heart.

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6 August 2019 chest X-ray

15. On 6 August 2019, Mr A suffered chest pains again and was taken by ambulance to the ED. He was admitted to hospital, and a chest X-ray was taken. Mr A told HDC that he was not told of any abnormality on the X-ray.

16. The radiology report, signed on 6 August by Dr E of an off-site radiology service (the radiology service), does not identify any suspicious masses. The X-ray images were reviewed following the events described below, and the report was amended by the radiology service on 18 February 2020. The amendment by Dr H (also of the radiology service) states:

> '… On the second film obtained, there is the impression of a 15mm density overlying the anterior aspect of the right third rib, however this is subtle, and is not convincingly identified on the first image, on a background of relatively poor inspiration.'

17. The Te Whatu Ora discharge summary dated 9 August 2019 records the primary diagnosis as angina. Some adjustments were made to Mr A's medications, and he was discharged with a plan for follow-up with his GP.

10 August 2019 chest X-ray

18. On 10 August 2019, Mr A again experienced chest pains, and he could not lift his right arm. He was seen by an acute demand nurse at his home. He was then taken immediately to the ED by ambulance. He was admitted to hospital, and a chest X-ray and a head CT scan were performed. He was not told of any abnormality on the X-ray.

19. The radiology report, signed on 10 August by Dr I of the radiology service, also does not identify any suspicious masses, although it does note: '[T]he lungs are underexpanded and hence pulmonary[3] assessment is limited.'

20. Mr A was monitored in hospital for a few days, and again his medication was adjusted, and he was discharged on 15 August 2019 with a plan for follow-up with his GP and a liver function test. The discharge summary records the primary diagnosis as unstable angina.

29 August 2019 chest X-ray

21. On 29 August 2019, Mr A experienced pain in his right side, and was weak and unable to mobilise. He was taken to ED again and admitted, and a further chest X-ray was taken. He was not told of any abnormality on the X-ray.

22. The radiology report, signed on 30 August 2019 by Dr J of Te Whatu Ora, states:

> '19mm nodule in the right lower zone is more conspicuous compared to 10/8/2019 and appears to be new compared to 29/1/[20]19 … CT chest recommended to characterise if clinically appropriate.'

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[3] Relating to the lungs.

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23. Te Whatu Ora told HDC that Mr A was discharged on 30 August 2019 before the radiology reporting on his chest X-ray became available, and therefore his discharge summary did not include the findings of the reporting radiologist.

24. The discharge summary again recorded the primary diagnosis as unstable angina. The summary does not mention Dr J's findings and was not updated subsequently to include them. The discharge plan was for GP follow-up and 24-hour blood pressure monitoring.

25. On 2 September 2019, the general medicine physician responsible for Mr A's care, Dr B, accepted Dr J's report in the Te Whatu Ora computer system. Dr B took no further action on the report.

October 2019

26. On 6 October 2019, Mr A experienced pain in his right side, and was weak and unable to mobilise. He was taken to ED again and admitted, and a further chest X-ray was taken.

27. The radiology report, signed on 6 October 2019 by Dr K of the radiology service, states:

> 'Within the mid to lower zone of the right lung there is a lobulated mass-like density which measures 35 x 31 mm. This has increased in size compared with the previous chest x-ray … Given the relatively short interval increase in size this could be inflammatory and could represent an area of infection. A rapidly enlarging mass would also have to be considered. Please correlate clinically with low threshold for CT. I note CT chest was recommended on the prior x-ray report. Has there been CT of chest since that study?'

28. On 7 October 2019, Mr A was seen by the respiratory registrar, Dr D. Dr D advised Mr A that there would be further investigations to confirm suspected lung cancer. He then had some further tests, including a CT scan.

29. The radiology report of the CT scan, signed by Dr L of Te Whatu Ora on 7 October, states: 'Right middle lobe invading across horizontal fissure to involve the right upper lobe. Appearance is consistent with primary pulmonary malignancy.'

30. The discharge summary records the primary diagnosis as: 'R[ight] sided chest pain likely secondary to lung mass, not angina.' The summary also notes the radiologist's report from 30 August, including the fact that the earlier report noted a possible mass on Mr A's right lung, and that this finding was not investigated further despite the reporting radiologist's recommendation. There is no evidence in the patient notes that this missed finding was discussed with Mr A during this admission. Mr A was discharged on 9 October pending further investigation of the lung mass.

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November 2019

31. On 5 November 2019, Mr A underwent a fine needle aspiration biopsy (FNA).[4] An X-ray performed on the same day noted that the mass in his right lung had increased in size to 45mm.

32. Dr D provided HDC with details of involvement in Mr A's care, including a discussion with Mr and Mrs A on 14 November following the FNA. Dr D informed Mr A that he had lung cancer. Dr D also told Mr A that the X-ray of 29 August had reported a 19mm mass in the lung and had recommended further investigation by way of a CT scan of the chest. Dr D said that Mr and Mrs A had not been told this previously, and Dr D advised them of their right to approach the Patient Advocacy Service if they wanted to find out more about what had happened at that time.

33. Mr A told HDC that at this time, Dr D showed him on the computer screen the increase in size of the mass between August and October 2019.

34. Subsequently, Mr A was offered a choice between radical radiotherapy aimed at curing his cancer, with the likelihood of significant side effects and a negative impact on his quality of life and independence, or palliative radiotherapy aimed at controlling the cancer growth with less treatment toxicity. Mr A chose radical radiotherapy. Sadly, despite the treatment, Mr A died from lung cancer in 2020. I extend my condolences to his family.

Mr A's complaint

35. Mr A complained to HDC that decisions were made without his knowledge concerning his condition and treatment. In particular, he said that on 29 August 2019 he was not fully informed of his condition, and he was not told about the abnormality on the X-ray or that a CT scan had been recommended. He told HDC that because he was not fully informed, he had no opportunity to question his treatment at that time.

36. Mr A also expressed concern that his frequent admissions to the ED prior to 29 August 2019 could have been an indicator of the lung cancer and should have been investigated further.

Te Whatu Ora's response

Failure to action radiologist's 30 August 2019 recommendations

37. Te Whatu Ora stated:

> '[Te Whatu Ora] acknowledges that after thorough investigation and audit of [Mr A's] care and referrals, we have no written documentation of a referral to the [r]espiratory department immediately following [Mr A's] August admission … Ideal practice would be for all referrals to be in writing. That is the normal practi[c]e at CDHB. However, it has been considered reasonable to provide a phone referral on occasion in situations of this kind. Normally the phone referral would be followed with a written record of the referral and CDHB apologise[s] that this did not occur in this case …'

[4] A fine gauge needle is inserted through the skin into the suspicious mass and some cells from the mass are taken for analysis.

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38. Te Whatu Ora provided HDC with a copy of its policy, 'Radiology Service SMO RMO: Communication of Critical/Actionable Results Policy'. The policy requires radiologists to ensure that a report of any significant new or unexpected abnormality is communicated to the referring clinician successfully. For lung nodules on a chest X-ray, that communication is to be made within three days. Although radiologists can monitor whether receiving clinicians have accepted the report, there is no expectation for the radiology department to follow up or ensure that further action is taken.

39. Te Whatu Ora's Chief of Radiology, Dr C, observed that there is a known gap in closed loop processes[5] — in which there is no mechanism for the team that receives an actionable radiology finding to feed back to radiology that there has been a decision to take an approach other than to order the further imaging recommended by the reporting radiologist. The result of this gap is that radiologists cannot know whether the report's recommendations have been overlooked or departed from intentionally. Dr C said that there has been no local solution to this, but other senior Te Whatu Ora clinicians are supportive of exploring options.

Consultation on treatment decisions

40. Te Whatu Ora told HDC that it does not believe that decisions were made concerning Mr A's condition and treatment without his knowledge, but that they understand why this perception of events has arisen.

Care in Emergency Department

41. Te Whatu Ora also investigated Mr A's concerns about his care in the ED. Te Whatu Ora acknowledged that on each ED admission in 2019 prior to 6 October, Mr A was told that he had unstable angina or muscle pain, and he was not told of any abnormality on his chest X-ray until the 6 October admission. However, Te Whatu Ora told HDC that the Clinical Director of the ED reviewed Mr A's notes and radiology images and is confident that the diagnoses made at the time were appropriate given the information available.

Radiology reporting

42. A Te Whatu Ora peer review of Mr A's imaging agreed with all the radiology reports, except for the 6 August 2019 chest X-ray report. The peer reviewer found:

> '6 August 2019 — There are two images, the second presumably taken because the first was rotated. Retrospectively, on the second image only, the lesion is visible as a 15 mm nodule, but the lungs are under-expanded and there are multiple normal vessels and ribs overlying the nodule. I think I would have reported a "possible" nodule and suggested a repeat/follow-up CXR with a better inspiration.'

43. Dr C summarised the peer review as follows:

> 'Lung nodules/masses are difficult to detect on chest x-ray (which is why CT is used for screening). The peer reviewer has indicated … the lesion is possibly visible on the 6

[5] In this case, a closed loop process would indicate that the reporting radiologist is made aware of the actions taken as a result of their report.

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August 2019 but only from one view, otherwise only definite on the 29 August 2019 when it was reported.'

44. The peer reviewer also noted that retrospectively there is a subtle opacity in the location of the lesion on the 10 August 2019 chest X-ray, but she would have interpreted that as normal blood vessels in an under-expanded lung.

45. Te Whatu Ora told HDC that it believes it is easier to spot abnormalities in retrospect, and that the reporting of Mr A's imaging was reasonable.

Delay in advising Mr A about his cancer diagnosis

46. HDC obtained independent advice from medical oncology consultant Dr Orlaith Heron, which included a recommendation for training for Te Whatu Ora clinicians on breaking bad news. In response to this recommendation, Te Whatu Ora told HDC that it does offer its staff an opportunity to attend a 'Serious Illness Conversation Guide' training workshop, which aims to give clinicians the skills and confidence to use the Serious Illness Conversation Guide, which provides a framework for a targeted advance care plan conversation.

47. SMO Dr G told HDC that following the CT scan reporting on 7 October 2019, Mr A was advised that the report mentioned abnormalities that would need further investigation. Dr G said that discussion would have been quite general at this stage and would have avoided specific terms like 'malignancy'. Dr G's team did not see Mr A initially, and his team also did not order the CT scan. His team took over care on the morning of 7 October 2019 and monitored Mr A in hospital until 10 October, when he was discharged awaiting a biopsy.

Delay in advising Mr A of failure to action abnormal radiology report

48. Te Whatu Ora described to HDC the result of an investigation it carried out, partly into the delay in advising Mr A of the earlier failure to act on the 30 August 2019 radiology report. Te Whatu Ora stated:

'As part of this investigation, our General Medicine CD [Dr F] has spoken directly with our General Medical Registrar [Dr M], who we believe was advised by our Respiratory Registrar [Dr D]. He was asked at the time of this incident to notify the patient, and the prior general medicine team, of this earlier significant result of [Mr A's] X-ray showing lung cancer.

[Dr M] has no recall of the case, with some time passing since its occurrence. He is aware that in a circumstance where a diagnosis had previously been overlooked, there must be transparency with the patient, and we are confident that is how he practices his medicine now. [Dr M] also noted that his practice would include discussing this result with his ward senior/consultant (SMO). He is also aware that any conversation had with a patient around this would be documented clearly in the patient's notes.

[Dr F] notes that at that time the general medicine department [was] documenting on the electronic cortex patient record system, while the respiratory team were still using paper notes. This may provide some possible explanation as to how this important information and reminder was overlooked, especially in the context of a service that is

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as busy as general medicine can be. CDHB regret the use of two systems (electronic and paper based) may have contributed to this unfortunate error.

CDHB continues to progress departments across from paper-based notes to our electronic system (Cortex) and all inpatient services at the [public hospital] campus are now using Cortex.'

49. Te Whatu Ora provided HDC with a copy of its open disclosure policy. That policy requires staff to participate in open communication with patients and their whānau whenever a patient in the care of Te Whatu Ora has been exposed to possible harm resulting from a system error that affected that patient's care, or when a patient has suffered harm while receiving health care.

50. The open disclosure policy also states:

'All events where a patient/consumer is harmed must be acknowledged to the patient/consumer and their support person as soon as possible (preferably within 24 hours) after the event is identified … Information about an event that causes harm must be given to the patient/consumer and/or support person in a timely, open and honest manner.'

51. In respect of the expectations of patients, the policy states:

'The patient and/or support person … may reasonably expect to be … fully informed of the facts surrounding an event where harm has occurred and the consequences of that harm.'

Delay in FNA following referral

52. Mr A received his FNA on 5 November 2019 following a referral on 7 October 2019. The referral request was dated 7 October 2019 and had a target date of less than two weeks. Te Whatu Ora told HDC that over that time period, strike action by medical imaging technicians had an impact on scheduling of outpatient appointments. Te Whatu Ora acknowledged that the target timeframe for outpatients was not always achieved during that time.

Dr B's response

53. Dr B initially told HDC that when he became aware of the 30 August 2019 radiology report, he had a conversation with respiratory registrar Dr D about further follow-up, which included doing a CT scan and a counselling session. Dr B said: 'This was deemed as a less traumatic way to deliver the news and was acceptable to both myself and the respiratory registrar.'

54. Dr D's first involvement in Mr A's care was on 7 October 2019, when he was referred by the General Medical Team following a CT scan of his chest.

55. After reading the correspondence from Dr D to HDC, Dr B accepted that the details he provided to Dr D may have been for another patient, and he may have mixed up the two

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patients, or given the wrong patient details, and therefore he did not refer Mr A to a respiratory specialist. Te Whatu Ora agreed that this is likely what happened.

56. Dr B told HDC that he did not document the conversation with Dr D, and he did not amend the 30 August discharge summary to include the reporting radiologist's findings. He said that this is because the other patient's radiology report showed almost identical findings to Mr A's, and this led him to believe, mistakenly, that both the reports were the other patient's. Consequently, he marked Mr A's report as accepted in the mistaken belief that he was accepting the other patient's results.

Radiology service response

57. The radiology service carried out offsite radiology reporting for Te Whatu Ora for several of Mr A's radiology images, including the chest X-ray of 6 August 2019. The reporting radiologist for the 6 August X-ray was Dr E. Dr E and the radiology service provided detailed information in response to HDC's request for information.

58. Dr E told HDC that he agreed with the radiology service's peer reviewer's assessment that there is a visible 15mm nodule on the X-ray, but he noted that there is a fine balance between reporting on possible lesions, and potential shadows or imperfections that are exacerbated on X-rays in which the patient's lungs are not sufficiently expanded. Dr E said that the peer reviewer identified the 15mm nodule retrospectively with the knowledge of what she was looking for, and he noted that it can be difficult to obtain clear images of patients who are in respiratory distress, as often they are short of breath and seated.

59. Dr E said that as he was being asked to comment on what was suspected to be a cardiac issue, he focused on a different X-ray image taken on 6 August, on which he could see the blood vessels better, but which did not show the 15mm lesion on Mr A's lung.

60. Dr E told HDC that he believes any miss is a learning experience, and he expressed sadness at Mr A's cancer diagnosis and death.

Further information

Mr A

61. Mr A told HDC that he was deeply distressed to hear that he had lung cancer. He said that he was angry and disappointed at the lack of respect shown by the medical staff who made decisions about his treatment without consulting him. He said that he felt they needed to understand the consequences of their actions, and he was extremely concerned that this might happen to someone else.

Te Whatu Ora

62. Te Whatu Ora apologised that the 30 August 2019 discharge summary was not amended with the radiology result, which both Mr A and his general practitioner would have received had it been duly updated.

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63. Te Whatu Ora also told HDC:

> 'CDHB unreservedly apologises for the delay [Mr A] experienced in being referred to respiratory. This led to his latter understandable belief that he had not been fully informed, nor given the opportunity to question his treatment at the time and [Mr A's] belief that the CT should have been performed earlier. We deeply regret that CDHB has not been able to reassure [Mr A] that any delay was due to a matter of timing around his discharge and the oversight in updating the discharge summary once the x-ray result had been reported, recommending a follow-up CT scan. If this had occurred, earlier awareness of the lack of that referral would have been triggered and [Mr A's] GP would also have been aware of [Mr A's] new diagnosis.'

64. Te Whatu Ora also said that it very much regrets not having been able to clarify and explain its care and clinical reasoning, and its plans for improvements, to Mr A while he was alive. Te Whatu Ora stated that it may have been reassuring for Mr A to have received the feedback that the delay of one month to get his follow-up CT would not have made any significant difference to the course of his very aggressive lung cancer.

Dr B

65. Dr B told HDC that he fully accepts the responsibility for the error of not acknowledging Mr A's radiology report, and hence the delay in the diagnostic work-up.

66. Dr B said that he was deeply saddened to hear of Mr A's death, and that he would like to wish Mr A's family his sincerest condolences.

Responses to provisional opinion

67. Mrs A, Dr B, and Te Whatu Ora were given the opportunity to respond to the Deputy Commissioner's provisional opinion. Neither Mrs A nor Dr B had any comments to make, and Dr B accepted the report and its recommendations. Te Whatu Ora's comments on the Deputy Commissioner's proposed recommendations have been incorporated into the recommendations section below.

Relevant standards

Medical Council of New Zealand, 'Disclosure of harm following an adverse event'[6]

'…

What should happen before disclosure of harm?

20. It is important that you make a disclosure in a timely manner. Therefore it is appropriate to make the initial disclosure as soon as practical, with a more detailed discussion with the patient to follow once the team has had an opportunity to meet and assess the

[6] https://www.mcnz.org.nz/assets/standards/b17273cc08/Disclosure-of-harm.pdf. Accessed 28 March 2023.

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circumstances that led to the patient being harmed. This will also give time for the patient to think about the situation and provide an opportunity to ask for more information.

…

22. While it may be more appropriate to disclose the harm in stages so the patient understands and processes the information without being overwhelmed, ongoing delay in giving full information is only acceptable if this is in the patient's best interests.

Disclosing harm

23. The senior doctor responsible for the patient's care should disclose the harm to the patient. Research indicates that patients prefer to hear from the doctor with whom the patient has established a rapport or had previous contact. In the situation where this is not the senior doctor, both practitioners should be in attendance. Research has shown that disclosure by hospital administrative staff or management alone is not well received by patients.'

Te Whatu Ora Waitaha Canterbury, 'Open Disclosure Policy'

'**Purpose**

This policy outlines Canterbury District Health Board's (CDHB)'s principles and expectations of staff participation in open communication with patients and their families (whānau) as part of normal work practice.

Scope/Audience

This policy applies to:

- All staff employed by Canterbury DHB.
- All visiting health professionals and students undertaking training or education within the organisation.
- All Canterbury DHB volunteers.
- All independent practitioners contracted to provide patient care.
- All contractors with Canterbury DHB, i.e. cleaners, security guards, etc.

Definitions

Open Disclosure

Open disclosure, or open communication, refers to the timely and transparent approach to communicating with, engaging with and supporting consumers and their families (whānau) when things go wrong.

NZ Health and Disability Services, 2012

On a practical level, open disclosure involves the staff and the health care organization acknowledging the incident/adverse event occurred, with an explanation of what happened, how it happened, why it happened; apologising when outcomes are less than optimal (things go wrong), and reassuring patients and their support person(s) of the

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measures taken to remedy it, and that the knowledge gained from such events will help prevent similar events in future.

The organisation needs to have appropriate processes in place to achieve these goals. An important part of the process is to ensure communication between health care professionals occurs, so that others can learn from potentially preventable adverse events.

…

Policy statement

Canterbury DHB expects all staff to participate in open communication with patients, and their family/whānau/support person(s), as part of their normal work practice, and in accordance with the consumers' Code of Rights and the Code of Health and Disability Services Consumers' Rights 1996.

Staff are to ensure that 'open disclosure' is provided whenever a patient in the care of Canterbury DHB has:

- Suffered any harm while receiving health care.
- Been exposed to possible harm resulting from a system error (mistake) that affected the patient's care but does not appear to have caused harm, or may not be immediately apparent.
- Suffered harm as a result of a complication of their health care management.
- Had their privacy breached, including information being mistakenly provided to the wrong person(s) or other health service providers or health professionals.

Acknowledgment

All events where a patient/consumer is harmed must be acknowledged to the patient/ consumer and their support person as soon as possible (preferably within 24 hours) after the event is identified.

Openness, timeliness and clarity of communication

Information about an event that causes harm must be given to the patient/consumer and/or support person in a timely, open and honest manner.

Interpreter services should be used when required to ensure information is communicated clearly and in the person's preferred language.

Apology

The patient/consumer and/or support person must receive an honest and genuine apology for any harm as soon as possible (ideally within 24 hours) after the event.

An apology must not include any admission to liability or fault, or apportion blame to any person(s) or the organisation.

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Recognition of the reasonable expectations of patients/consumers and their support person

The patient and/or support person/guardian/caregiver may reasonably expect to be:

- fully informed of the facts surrounding an event where harm has occurred and the consequences of that harm;
- treated with empathy, respect and consideration and to be provided with such support as is necessary in a manner appropriate to their needs;
- fully informed as to the outcome of any investigation undertaken together with any changes instituted as a result of that investigation.

…

Documentation

A summary of communication as part of the open disclosure process should be documented in the patients' health record.

Ongoing Care

When a patient/consumer has been harmed in the course of receiving health care any required further management or rehabilitation must be planned in discussion with the patient/consumer and/or support person in order to ensure that they are fully informed of and in agreement with any proposed ongoing care.'

Opinion: Dr B — breach

68. Independent advice from a medical oncologist, Dr Orlaith Heron, has assisted my investigation of this case. Dr Heron identified departures from the standard of care in respect of the failure to action the radiology report of 30 August 2019, and the delay in advising Mr A of that failure once it was discovered. I deal with the latter in the context of Te Whatu Ora's role later in this report.

69. Dr B was the physician responsible for Mr A's care during his 29 August 2019 admission.

70. During that admission, an X-ray of Mr A's chest was ordered in the context of suspected heart problems. However, the radiology report provided on 30 August identified a 19mm mass in the right lung. The report recommended a CT scan of Mr A's chest to identify the mass.

71. Mr A was discharged on 29 August, before the radiologist's report became available. The discharge summary noted the primary diagnosis as 'unstable angina'. The summary noted that a chest X-ray had been carried out, and that it had shown no sign of 'pulmonary oedema or pleural effusion', but it did not note that the radiologist's report was still outstanding.

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72. When the radiologist's report did become available, on 2 September, Dr B marked the report as accepted and took no further action on it. He also did not update the discharge summary with the results of the report, nor did he notify Mr A or his GP that it had been received.

73. Dr B told HDC that the reason for these omissions was that he had another patient on the same day with a similar name, and he received Mr A's report at the same time as the other patient's report. Dr B said he assumed that Mr A's report belonged to the other patient and, because the findings in the two reports were very similar, he took no further action on Mr A's report and marked it accepted in the hospital's computer system. Consequently, he did not update Mr A's discharge summary with the result, as he would do normally.

74. The result of Dr B's failure to take any further action on the radiologist's report was very serious. The CT scan recommended in the report was not carried out, and by the time the mass was identified a month later, it had increased in size substantially. Because the discharge summary was not updated with the result, Mr A and his GP were also deprived of the opportunity to take action on it.

75. Dr Heron advised that Mr A's lung cancer diagnosis was delayed by approximately four weeks. She said that if the result had been actioned, she would have expected a CT scan or respiratory review within two to three weeks (if there was a fast-track system for lung cancer) compared to the CT date of 6 October on Mr A's readmission.

76. Dr Heron also advised that although there was a delay in diagnosis, most likely this did not affect the outcome for Mr A as his cancer was rapidly growing, already large, and likely at an advanced stage.

77. Although I appreciate that earlier diagnosis may have been unlikely to have affected the outcome for Mr A, I remain critical of Dr B for failing to action the 30 August 2019 radiologist's report. As noted by Dr Heron, had the report been actioned immediately, the CT scan would have been carried out within two to three weeks, rather than a few weeks later. In the event, the 6 October scan was carried out because Mr A presented again to hospital with symptoms. Had he not done so, the interval may have been considerably longer.

78. Dr Heron advised that the most appropriate time for specialist referral would have been on acknowledgement of the abnormal X-ray report of 2 September 2019. Dr Heron considers that the lack of any record of a respiratory referral at this time is a serious departure from accepted practice. I accept that advice, noting that the failure to make a referral was the result of Dr B confusing Mr A's report with another report.

79. In a recent report,[7] the Health and Disability Commissioner found a senior emergency medicine clinician in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[8] for a failure to take action on a radiologist's report finding of an abnormal mass in a patient's lung, and accepting the report on a hospital computer

[7] 20HDC00717, available on https://www.hdc.org.nz/ Accessed 30 March 2023.

[8] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

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system without ensuring that any further action was taken. The relevant facts of that case are very similar to this case.

80. Because Dr B marked the 30 August radiologist's report as accepted without taking further action on it, Mr A was not advised of the presence of the mass, and opportunities were missed to diagnose and treat the cancer at an earlier time. For this reason, I find that Dr B failed to provide Mr A with an appropriate standard of care and breached Right 4(1) of the Code.

81. I note with approval that Dr B has fully accepted the responsibility for his error and has apologised to Mr A's family in his responses to HDC.

Opinion: Te Whatu Ora|Health New Zealand Waitaha Canterbury — breach

Open disclosure of harm — breach

82. At some point during Mr A's 6 to 9 October 2019 admission, he should have been informed of the earlier failure to action the 30 August radiology report. The abnormal finding in the 30 August report was explicitly noted by radiologist Dr K in the report on the 6 October X-ray. Dr D recalls discussing the error with Dr M and stating in that discussion that Mr A and Dr B should be informed. In the event, no one told Mr A that there had been a diagnostic finding of an abnormal mass on his lung more than a month earlier. As he rightly complained, because he was not fully informed, this deprived him of the opportunity to question his treatment with all the relevant information to hand.

83. Dr Heron commented on the Medical Council of New Zealand's statement on disclosure of harm following an adverse event (see Relevant standards above). She noted that it requires information about the adverse event to be disclosed to the affected patient in a timely manner by the senior doctor responsible for the patient's care. Delay is acceptable only if it is in the patient's best interests. I note that Te Whatu Ora's policy on open disclosure contains similar requirements, in particular that acknowledgement of the event should be made as soon as possible after it has been discovered (preferably within 24 hours), and information about the event should be provided in a timely manner. Such communication should be documented in the patient's record.

84. I also note that the policy requires the following:

> 'When a patient/consumer has been harmed in the course of receiving health care any required further management or rehabilitation must be planned in discussion with the patient/consumer and/or support person in order to ensure that they are fully informed of and in agreement with any proposed ongoing care.'

85. Dr Heron advised that the non-disclosure to Mr A as an inpatient is a moderate to severe departure from accepted practice. I agree with that advice. It is likely that Dr D discussed

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the abnormal finding with the general medical registrar, Dr M, including that Mr A should be advised of the finding. However, Dr M has no recollection of this discussion.

86. Given the sequence of events, it is difficult to attribute this failure to one individual. I note that although the Te Whatu Ora open disclosure policy does require timely disclosure of harm to a patient, there is a lack of clarity about who is to provide the disclosure, and whose responsibility it is to ensure that open disclosure is provided. Between 6 and 9 October, the prior abnormal finding was known to several different clinicians in two different departments, but no individual took responsibility for ensuring that Mr A was informed of the error. This highlights the importance of clear communication between different specialist teams. I consider that the failure to inform Mr A of the earlier failure to action the 30 August radiology report is attributable to systemic issues at Te Whatu Ora Waitaha Canterbury, including the lack of clarity in the open disclosure policy. Consequently, in failing to ensure that Mr A had all the information that a reasonable consumer in his circumstances would expect to receive, including the results of tests, I find that Te Whatu Ora breached Right 6(1) of the Code.[9]

Emergency Department and inpatient investigations — no breach

87. Mr A also expressed concern that his frequent admissions to the ED prior to 29 August 2019 could have been an indicator of the lung cancer and should have been investigated further.

88. Dr Heron advised that the ED and inpatient investigations of Mr A's chest pain presentations were appropriate. She said that acute coronary events were considered appropriately, and the appropriate tests carried out. Given the diagnosis of unstable angina, Mr A was rightly under the care of the cardiology team, and a CT scan of the chest would not be routine to rule out cancer in the presence of a normal chest X-ray, especially if another diagnosis were deemed more likely.

89. I accept that advice, and I find that with the exception of the findings elsewhere in this report, Mr A was managed appropriately in the ED and as an inpatient.

Opinion: Radiology service — no breach

90. It would be remiss of me to omit comment on the X-rays of 6 and 10 August 2019 and the radiology reporting on those X-rays. The X-ray of 6 August was reported on by Dr E of the radiology service — a third-party radiology service — and the 10 August X-ray was reported on by Dr I, also of the radiology service. No concerns were reported by either reporting radiologist in respect of those images.

91. In respect of the 6 August X-ray, a later review on 18 February 2020 by Dr H (also of the radiology service) found 'the impression of a 15mm density overlying the anterior aspect of

[9] Right 6(1) states: 'Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including … the results of tests …'

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the third right rib, however this is subtle, and is not convincingly identified on the first image, on a background of relatively poor inspiration'.

92. A review by Te Whatu Ora also found:

> '[T]he mass is visible as a 15 mm nodule, but the lungs are under-expanded and there are multiple normal vessels and ribs overlying the nodule. I think I would have reported a "possible" nodule and suggested a repeat/follow-up CXR with a better inspiration.'

93. In respect of the 10 August X-ray, the Te Whatu Ora reviewer found: '[R]etrospectively there is a subtle opacity in the location of the lesion.' However, she said that she would have interpreted that as normal blood vessels in an under-expanded lung.

94. Te Whatu Ora told HDC that it believes it is easier to spot abnormalities in retrospect, and that the reporting of Mr A's imaging was reasonable.

95. The Clinical Director of the ED reviewed Mr A's notes and the radiology images, and is confident that the diagnoses made at the time were appropriate given the information available.

96. In an ideal situation, the nodule on Mr A's right lung would have been identified on 6 August 2019. However, I am mindful that hindsight bias makes identification far more likely in retrospect. Given the variance in opinion on whether the nodule should have been identified and further investigation carried out, I am not critical of the radiology service or its radiologists that the nodule was not identified on the 6 or 10 August X-rays.

Changes made

Te Whatu Ora

97. Te Whatu Ora told HDC that it has made a number of changes since the events described in this report.

98. Te Whatu Ora said that it recognised that its referral process, and in particular the practice of telephone referrals, was an area that required system improvement. It has now implemented an electronic system for internal referrals, which ensures that all such referrals are recorded in writing. Te Whatu Ora provided HDC with a copy of the implemented procedure.

99. Te Whatu Ora's Open Disclosure Policy has not yet been reviewed, but it advised HDC that a review of the policy is a priority.

100. Te Whatu Ora also said that having reviewed this case, it has formalised its response to abnormal results that are received after a patient has been discharged, and it has documented the expectations in its general medical handbook. That update includes a

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requirement to amend the discharge summary (and the updated summary is then sent automatically to the patient's GP electronically). The handbook is part of new medical staff orientation into the General Medicine Department.

101. Te Whatu Ora also detailed a new general medical handbook procedure on communicating abnormal results to patients, which includes contacting the patient by telephone or, if it is distressing news, arranging an in-person appointment to discuss the result and ongoing plan. If appropriate, the patient's GP may instead be called and asked to call in the patient for an appointment to explain the result and next steps.

102. Dr F also indicated that as part of the learnings from this case, the department now emphasises in its protocols that full disclosure must occur when results are overlooked, and an incident report must be filed and the error recorded in the discharge letter. This is now noted in the general medical handbook, and the relevant excerpt was provided to HDC.

103. Te Whatu Ora also told HDC that the General Medicine Department now holds regular mortality and morbidity meetings in order to:

a) Critically analyse the care provided to a patient who has died;

b) Identify systemic problems;

c) Make recommendations for improvements;

d) Action and oversee the implementation of the improvements; and

e) Provide a supportive learning environment to review challenging cases.

104. Learnings from this case have also been discussed in various scheduled meetings of clinicians, and an education session was held with general medicine registrars on the Te Whatu Ora incident reporting system.

105. Te Whatu Ora also provided HDC with notes from a General Medicine Mortality and Morbidity meeting in April 2022 at which this case was discussed. Of relevance, the note records the following:

a) Abnormal radiology results now show up in red on the computer system.

b) The importance of awareness of patients with similar names or presentations was discussed.

c) Referrals to other services do not currently have a closed loop, but there is a plan for the future to have inpatient referrals online, which would resolve the issue.

d) The importance of openness and transparency to the patient and to the original teams was discussed.

e) The importance of documentation of all conversations was discussed.

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Dr B

106. Te Whatu Ora told HDC that a review of this case has resulted in change of practice personally for Dr B, and he also presented his perspective of this case at a peer review meeting in August 2020 to provide a further learning opportunity for his colleagues.

107. Dr B said that since the error with Mr A's 30 August radiology report, he has documented in the hospital's computer system any action taken after reviewing a report, including where he has made a referral, and any abnormal results.

Recommendations

Te Whatu Ora

108. I recommend that Te Whatu Ora:

a) Provide a formal written apology to Mr A's family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Provide an update to HDC on the urgent review of its open disclosure policy, and in particular how it is to be updated to prevent a future failure such as that identified in this report, and who has responsibility to disclose harm to the patient. The update is to be sent to HDC within three months of the date of this report.

c) Provide an update to HDC on the plan to include patient referrals (including referrals that are to be actioned after a patient is discharged) to other services on Health Connect South and to ensure a closed loop system is implemented. The update is to be sent to HDC within three months of the date of this report.

d) Audit compliance with the requirement to update discharge summaries with abnormal results that are received after a patient has been discharged, and compliance with sending the updated summary to the patient's GP. Te Whatu Ora should take a random sample of 50 discharge summaries from the 12 months preceding the date of this report and compare each summary against the patient record to determine whether:

    i. The patient had test results outstanding on discharge;

    ii. Whether the discharge summary was updated with the result; and

    iii. Whether a copy of the updated discharge summary was sent to the patient's GP.

    The results of the audit are to be sent to HDC within three months of the date of this report.

e) Introduce a further requirement that discharge summaries note any results that are still awaiting reporting. In particular, Te Whatu Ora should consider stipulating in a relevant process document a requirement to document outstanding test results and provide for

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how this will be communicated or actioned (especially if it is abnormal). The results of that consideration should be reported to HDC within three months of this report.

f) Audit compliance with its current policy on open disclosure, in particular the requirement that (if possible) disclosure has been made within 24 hours, and any communication with the patient documented in the patient's record. The sample should include a random sample of 10% of recorded incidents from the 12 months preceding this report where the need for open disclosure was identified. The results of the audit are to be sent to HDC within three months of the date of this report.

g) Where any audit recommended above results in corrective action to address shortfalls, I recommend that Te Whatu Ora carry out a further audit three months from the implementation of the corrective action to assess the effectiveness of the corrective action. Te Whatu Ora is to report to HDC on the results within six months of the implementation of the corrective action.

h) Provide to HDC a copy of the section it has added to its Electronic Health Pathways documents advising clinicians on what to do should an unexpected actionable finding be reported by Radiology, within three months of the date of this report.

Dr B

109. In accordance with the recommendation in my provisional opinion, Dr B provided a formal written apology to Mr A's family, and this has been forwarded to the family.

110. I recommend that Dr B arrange for an audit of 50 radiology reports he has acknowledged in the six months preceding the date of this report, to identify whether significant abnormal findings are being actioned, and report the results of the audit to HDC within three months of the date of this report.

Follow-up actions

111. A copy of this report with details identifying the parties removed, except the advisor on this case and Te Whatu Ora Waitaha Canterbury, will be sent to the Medical Council of New Zealand and the Royal Australasian College of Physicians, and they will be advised of Dr B's name in covering correspondence.

112. A copy of this report with details identifying the parties removed, except the advisor on this case and Te Whatu Ora Waitaha Canterbury, will be sent to Te Aho o Te Kahu|Cancer Control Agency and Te Tāhū Hauora|Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Orlaith Heron, a medical oncology consultant:

'Deputy Health and Disability Commissioner, here is my report on the case of [Mr A], C20HDC00132.

1. Whether the care provided during admissions was appropriate and consistent with accepted standard of practice

Emergency Department and inpatient investigation of chest pain presentations were appropriate and standard of care. Most pertinently, acute coronary events were considered. Blood tests included cardiac investigation (Troponin, BNP), inflammatory markers (CRP) and routine bloods (Full Blood Count, liver and renal). From [Dr D's] notes unstable angina was diagnosed and [Mr A] was appropriately under the care of the cardiology team. CT chest would not be routine to rule-out cancer in the presence of a normal Chest XRay (CXR) especially if another diagnosis was deemed more likely. My peers would concur.

Abnormal CXR was reported on 30/08/2019 at 16.39 which was after [Mr A's] discharge.

October admission resulted in CT and near immediate respiratory review 07/10/2019. [Dr D] reports requesting CT FNA and pulmonary function tests with follow up in lung cancer clinic. These investigations are important and urgent but not an emergency so standard of care is to perform them quickly in the outpatient setting.

[Mr A] was not informed of the earlier abnormal CXR report or its missed actioning during admission. [Dr D] recalls discussing with the General Medical Registrar who referred [Mr A] that he should be informed and [Dr B] updated as the treating clinician from that admission. This recommendation was made from consulting registrar to treating registrar. I do not know if this conversation was formally documented, escalated to [Dr G] (who had informed [Mr A] of the presumed lung cancer) or if [Dr B] was informed of the diagnostic error (diagnosis that was unintentionally delayed by nonreferral). The Medical Council's statement on disclosure of harm following an adverse event advises a senior doctor responsible for the patient's care disclose the information; [Dr G] or [Dr B] in this case. The Council advise disclosure in a timely manner and a delay in relaying information is only acceptable if in the patient's best interest. This non-disclosure to [Mr A] as an inpatient would be a moderate to severe departure from accepted practice and I believe my peers would uphold this view.

Recommendations for improvement that may prevent a similar occurrence in future:

- Referral System — This case highlights why verbal referrals are largely being phased out; they pose a quality and safety issue. E-referral systems are preferential as an automatic receipt of acknowledgement is sent to the referrer and with this system it is easy to check if referral has been made/received/booked.

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- If a treating team ([Dr G's] team in this case) become aware of an unacknowledged or unactioned result, I recommend disclosure of this during admission.
- I recommend that this case is presented at a Morbidity and Mortality meeting by [Dr B]. It is an excellent example of breaking bad news, the peril of lack of continuity of care faced in an acute setting and breakdown in handover/referral.
- If practitioners are uncomfortable with breaking bad news, I encourage engagement in a communication workshop. It must be acknowledged that this is a challenging conversation for many and some practitioners may feel ill-equipped.

2. In particular, whether or not there was a delay in diagnosing [Mr A's] lung cancer

[Mr A's] lung cancer diagnosis was delayed by approximately 4 weeks. [Dr B] acknowledged the CXR result Monday 2nd September. If the result was actioned, I would expect CT or respiratory review within 2–3 weeks if there is a Fast Track System for lung cancer. This is compared to CT date of October 6th on readmission. No person would refute delay in diagnosis.

3. Whether or not the delay in one month in getting [Mr A] a follow-up CT scan was of any material significance to the likely outcome of his diagnosis

Although there was a delay in diagnostic work up, this most likely did not impact the outcome. [Mr A] had a poorly differentiated rapidly growing ALK mutated lung cancer. Given his age, cancer position (grew across horizontal fissure to involve more than one lobe) and co-morbidities, radical radiation was recommended over combined chemoradiation or surgery. From Dr … letter, [Mr A's] preference was radical radiation and he wished to avoid chemotherapy. Earlier CT would not have changed treatment recommendation. The small pleural effusion on PET-CT 25/11/2019, although non-specific and small, is concerning for more advanced disease. If CT had occurred at the time of abnormal CXR report, PET date would have become the approximate date of radiation commencement. Although there was no nodal involvement or metastatic disease, the primary was large (T4) and displaying adverse biological features with the speed of growth.

I believe my peers would agree there was a delay in diagnosis but this most likely did not affect the outcome. The Canterbury DHB response suggests that this was discussed with one of their Oncologists (unnamed) who shared this view.

4. The appropriate time to inform a patient about what the result of a test could indicate, before a definitive diagnosis is made

The most appropriate time is during daylight working hours shortly after receipt of the abnormal result. In this case, CXR was reported after discharge adding an extra complexity to informing the patient. In [Dr B's] response letter "a clinic where he could be informed in person and explained the finding as well as the work up … was deemed a less traumatic way to deliver news". An abnormal CXR indicates possible cancer and is not a definitive diagnosis. It was the responsibility of [Dr B], the ordering consultant, to ring or arrange an interview with [Mr A] to disclose the result. Without disclosing an

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abnormal result which warrants further investigation, a patient will receive further clinic or imaging appointments with no knowledge why these appointments are required or what they are for. There would not be 100% consensus among peers on the best approach to this scenario and the approach taken influences timing of disclosure. Some practitioners are uncomfortable having these conversations on the phone rather than in person.

5. Was appropriate specialist input sought at the right time

The most appropriate time for specialist input referral was on acknowledgement of abnormal CXR report 02/09/2019 (CXR taken 29/08/2019). The date of acknowledgement is appropriate as CXR was reported late afternoon on a Friday. There is no record of respiratory input request at this time and this is a serious departure from good medical practice. In [Dr B's] response letter, he accepts responsibility for delayed respiratory referral. He believed he had verbally referred but acknowledges he was mistaken.

Specialist input (respiratory) was requested and received the same day as CT confirming likely malignancy (07/10/2019). This was expeditious.

6. Were all appropriate tests, scans and assessments undertaken

Yes, pulmonary malignancy work-up was appropriate and pertinent investigations undertaken including PET-CT to access if there was the possibility of treating with curative intent.

7. Any other matters in this case that you consider amount to a departure from accepted standards

No.

Yours sincerely,

Dr Orlaith Heron

29/04//21'

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